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ABSTRACT

This collection of six case studies is a by-product of a European-focused study that sought to understand the policies focused on children from birth to age 3, whether directly affecting the children or reaching them indirectly through their parents. The study examined the social infrastructure in which the specific "under-3" policies are embedded, or on which they rest. Program and policy exemplars with the potential to alter policy in the United States were selected for this report. The report is organized into six chapters individually addressing the six case study nations of: (1) Denmark; (2) Finland; (3) France; (4) Germany; (5) Italy; and (6) United Kingdom. Each of the cases is organized into four main sections: (1) an overview; (2) general child and family policy; (3) the specific under-3 measures identified and explicated; and (4) context--demography, expenditures, political and economic forces. In each case report, a final "On the Ground" section offers excerpts from program observations in child care, maternal and child health, and family support services. The appendix section consists of background tables to orient readers to basic facts about the countries detailed and some of their differences. (SD)

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SOCIAL POLICY AND THE UNDER-3S
SIX COUNTRY CASE STUDIES

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A Resource for Policy Makers, Advocates and Scholars

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1994

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4

INTRODUCTION

This collection of six case studies is a by-product of a study focused on European developments affecting infants and toddlers, and constitutes part of the documentation of that study. The overall study sought to understand the policies focused on children from birth to age 3, whether directly affecting the children or reaching them indirectly through their parents. It asked, as well, about the social infrastructure in which the specific under-3 policies are embedded, or on which they rest.[1]

Our objective, however, was to affect U.S. policy. Thus, what we have learned in the European Study is being drawn upon in explicating the case for "Starting Right" in this country. We have selected, for that report, program and policy exemplars in the United States and elsewhere, but particularly in Europe, which offer viable options as the country seeks to improve the situations of young children and their families.

Because of its ultimate concern with U.S. policy, the book, Starting Right: Investing in the Youngest Americans, does not constitute an adequate research report or documentation of the European study. To offer policy makers, advocates, scholars and others access to the European materials omitted or referred to only briefly, we have assembled each country's story as a "case". We find that this facilitates our own use of the material, while making it accessible to others.

These materials should be considered, as well, in connection with our 1991 book, Child Care, Parental Leave, and the Under 3s,[2] and our 1981 book, Child Care, Family Benefits and Working Parents[3], which go over some of the same ground (the latter at a much earlier stage of development), but cover other topics as well in some of these same countries and a number of others.

The countries were chosen in relation to the study design. Three had announced explicit policy for the under-3s, two addressed the under-3s in the context of overall child and family policy. The sixth, England, like the United States, lacks explicit family policy, but has more extensive social policy covering health and universal cash child benefits. These choices might highlight the importance, or lack of importance, of explicit "under-3" measures, as contrasted with general child and family policy, and enrich the understanding of social infrastructure.

The cases follow one outline, adapted to the country specifics:

- An Overview
- General child and family policy
- The specific under-3 measures identified and explicated
- Context: demography, expenditures, political and economic forces.

In each case report, a final "on the ground" section offers excerpts from our program observations (as relevant) in child care, maternal and child health, and family support services.

These data were assembled over a two-year period between 1991 and 1993 involving at least two periods of time in each country. During the first round of visits we concentrated on policies, laws, finances, politics, history, demography - interviewing and collecting materials. During the second year we filled in gaps in our materials and understanding and concentrated on field observations at several locations in each country. Obviously, there is no pretence at a random, representative, or adequate "sample". We visited so as to be able to visualize programs, discuss issues with personnel engaged in the work, and see what leadership personnel described as 'solid', 'transitional', or 'exemplar' programs.

We have included a series of background tables in an Appendix to orient readers to basic facts about the countries and some of their differences. Demographic and labor force data are reported in the text as of the time our case studies were launched, with some updating in the Appendix tables, but no effort to make them completely current since we wanted to report the data we discussed with officials and program personnel.

The "sample" covers all of Europe's big countries, Germany in a size-class of its own and Italy - France - U.K. in the same group; and we have two small Nordic countries with very interesting stories, Denmark and Finland.

As will become apparent at once we are in the debt of many public officials, administrators, and scholars in these countries - as well as many practitioners doing their jobs "on the ground" One or two experts in each country reviewed each completed "case" for factual accuracy and to query interpretations. The final drafts of course are our responsibility.

None of this would have been possible without the Carnegie Corporation (and Michael Levine, in particular) and the Spencer Foundation (and Linda May Fitzgerald).

We completed our field work and had it checked for accuracy by country experts in the period between the summer of 1991 and the summer of 1993. Our "cases" are not fully up to date on modest budgetary and benefit cut-backs during late 1993 and 1994 in some countries (and increases and expansion in others), in the midst of economic slowdown and high unemployment in these countries. Nonetheless, our primary purpose is not undermined: a picture of family policy affecting very young children in its societal context. What is more, while unemployment insurance and sickness insurance experienced substantial or modest cut backs in several places (leaving benefit levels still generally unmatched in the U.S.), the character of the policies in focus here was unaltered. We did see some decrease in child care demand in Finland, reflecting unemployment and (as the report notes) East Germany was in transition.

AJK and SBK

NOTES

[1] Other reports of this research appear in:
- Sheila B. Kamerman and Alfred J. Kahn, "Home Health Visiting in Europe", The Future of Children. Vol. 3, No. 3 (Winter, 1993), pp. 39-52, Special Issue, Home Visiting.
- Sheila B. Kamerman and Alfred J. Kahn, A Welcome for Every Child: Care, Education and Family Support for Infants and Toddlers in Europe (Arlington, VA: Zero to Three, The National Center for Clinical Infant Programs, 1994).
- Sheila B. Kamerman and Alfred J. Kahn, "Family Policy and the Under 3s: Money, Services, and Time in a Policy Package", International Social Security Review, forthcoming.
- Sheila B. Kamerman and Alfred J. Kahn, Starting Right: Investing in the Youngest Americans (New York: Oxford University Press, 1995).

[2] Sheila B. Kamerman and Alfred J. Kahn, eds., Child Care, Parental Leave, and the Under 3s: Policy Innovation in Europe (Westport, CT: Auburn House, 1991).

[3] Sheila B. Kamerman and Alfred J. Kahn, Child Care, Family Benefits and Working Parents: A Study in Comparative Family Policy Analysis (New York: Columbia University Press, 1981).

* *

About Age Groupings

0-3 refers to children ages 0-1, 1-2, 2-3
3-6 refers to children ages 3-4, 4-5, 5-6

EC-EU

Although the EC is now the European Union, our citations are in relation to the time of publication or the substance under discussion.

About Fees and Salaries

To assist United States readers and others who read cases covering countries other than their own, we have converted fees and salaries into U.S. currency equivalents for the relevant year, 1991 or 1992 (or earlier years in some instances). For those interested as well in the relative purchasing powers of the currency, the table at the front of the Appendix also provides purchasing power parities. Where tables refer to European Currency Units (ECU's) reference may be made to the dollar equivalents for 1991-2-3, which we have provided.

TABLE OF CONTENTS

	Pages
Introduction	iii - vii
Denmark	D1 - D131
Finland	FI1 - FI89
France	FR1 - FR90
Germany	G1 - G98
Italy	IT1 - IT70
United Kingdom	UK1 - UK120

Appendix Tables

- A-1 Exchange Rates, Purchasing Power Parities, and ECU Values
- A-2 Average Gross Earnings of Production Workers in Own Currency, 1992
- A-3 Demography
- A-4 The Under-3s in the Countries Studied
- A-5 Foreign Populations in the Countries Studied
- A-6 Fertility, Infant Mortality and Life Expectancy
- A-7 Employment: Labor Force
- A-8 Employment: Part-Time
- A-9 Labor Force Participation of Women with Young Children
- A-10 Public Sector: Government Revenue, Expenditure, Employment
- A-11 Taxation
- A-12 Relative Poverty Rates, Selected Countries
- A-13 Family Allowances, Selected Industrial Countries, 1991-1992
- A-14 Basic and Job Protected Maternity/Parental and Extended Parental Leaves OECD Countries, 1991-1992
- A-15 Child Care Coverage Rates for Children Aged 0-3 and 3-5 in Selected Countries, 1990/1992

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SOCIAL POLICY AND THE UNDER-3S

THE CASE OF DENMARK

Table of Contents

PAGE

INTRODUCTION ....D 4

CHILD AND FAMILY POLICY ....D 6

1. Child Allowances ....D 6
2. Advance Maintenance...............................D 8
3. Maternity and Parenting Benefits..................D 9
4. Care of A Sick Child..............................D 11
5. Maternal and Child Health.........................D 12
6. Child Care Services...............................D 18
7. Parent Education and Family Support...............D 36

CONTEXT ....D 37

1. Demography and Social Trends......................D 37
2. Expenditures ....D 43
3. The Political and Economic Forces.................D 47

ON THE GROUND ....D 51

1. Child Care..D 51
   Child Care in Hvidovre.............................D 55
   Child Care in Aarhus ....D 64
2. Family Day Care In Two Communities ....D 76
3. Home Health Visiting ....D 89
   Discussion...D116

CONCLUSIONS..D120

NOTES D124

REFERENCES D128

List of Tables

PAGE

Table DK-1 Denmark: Expenditures for Family Social Benefits, Millions of Kroner and Percents (1991)...D18x

Table DK-2 Denmark: Child Care Coverage by Age Groups (1992 in Percentages) D20

Table DK-3 Danish Child Care Average Annual Total Operating Costs....................................D27

Table DK-4 Expenditures for Family Benefits in Nordic Countries, 1978-90, In Percentages of Total Social Expenditures and as a Percentage of the Gross National Product..D46

INTRODUCTION - THE DANISH WELFARE STATE

The Danish rapporteur to the European Community's "Family Observatory" project sums up as follows:

> Denmark has no tradition of formulating a special family policy. This means that Denmark has no ministry for handling family policies. Nor is there a ready-made family viewpoint which is consistently applied to legislative and administrative practice. Finally, Denmark may be said to have no special ideological framework within which to place the family as an institution[1].

Nonetheless, within a public policy framework which seeks neutrality with regard to family forms, and thus focused largely on individuals, one observes that in Denmark the family remains not only a "social unit of significance ... to the everyday life of the individual" but also a unit significant for "legislative and administrative practice". Indeed, the individualization of policy in fact "has resulted in special attention being given to children and families with children. ... Danish family policy is focused on families with children and, above all, families with small children. This emphasis in family policy has become increasingly visible over the last ten years, assuming a shape which makes it reasonable to speak of Danish family policy in terms of a focus on child policy".[2]

In a comparative perspective, Denmark does have a family policy, in part explicit and in part implicit, all relatively coherent. This, despite lack of a formal mechanism to guide such policy except for an interministerial committee and an active parliament.* And the policy is focused on children. While age boundaries are not specified, numerous documents and statements refer to "small children", usually meaning children under school age (7).

The context is that of a generous Scandinavian welfare state which evolved during the period when Bismark was developing social insurance in Germany, but was based in the peasantry and an enlightened mercantile class. It has emphasized universalism, rather than contributory benefits - but the pattern is not pure. (There have been some departures from universalism in recent years). Nonetheless, most benefits are flat rate. Danish unemployment insurance has been generous, but its labor market policies have not been dramatically "active" in the Swedish sense. A general national health service covers everyone and has no "insurance" (contributory) features. The national health service involves a publicly funded and administered delivery system. Social assistance has been generous, comparatively, since the 1970s, offering a living standard that is viable. While overall housing policy is modest by European norms and there is considerable reliance on the market in this field, grants to the poor - which are means tested - are graduated and contribute substantially to a decent housing standard for most low-income families with children. Education on all levels is public, universal, of high quality, and accessible.

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* Denmark in fact once had a family ministry but discovered, as have many countries, that the subject matter belonged to several ministries. Hence the various interministerial coordination devices.

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A special feature of Denmark's government (as of the Nordic countries generally) is the high degree of decentralization. Despite the fact that most social programs are nationally financed, even cash benefits are delivered at the local level. Municipal social welfare committees are set up as the "administrative nuclei" of this system.[3] Denmark is the most decentralized of the EC countries in its local delivery of welfare policy.[4] Whereas in some other Scandinavian countries grants from the center are quite specific, much of Danish municipal income has no strings attached. An American would recognize many Danish municipality responsibilities as covering what U.S. cities and counties do, except that in Denmark the list also includes social security and some medical-dental services.[5]

Although Denmark identifies and is concerned with several relatively disadvantaged groups, for some time it has had little or no poverty in the United States sense.

CHILD AND FAMILY POLICY

We begin with aspects of policy relevant to all children and, then, emphasize child care and health visiting, two aspects of what is offered to "small" children and their families in which Denmark may be said to be among the leaders.

1. Child Allowances.

Danish taxation focuses on the individual, and family structure has no significance. There are no special family tax deductions. In fact, a recent EC report documents the fact that Denmark uses the tax system for family policy least within the

Community.[6] Moreover, while the national tax system is progressive, much of the progressivity has tended to be eroded by a heavy burden of regressive indirect and local taxes. Further, upper income groups do benefit from a generous system of deductions (which is currently being cut back in a series of reforms).

Family financial aid comes, rather, through a system of untaxed, universal family benefits, in the current form unrelated to income. These benefits (which supplement earnings, pensions, unemployment benefits, social assistance, etc.), originally enacted in their present form in 1987 and improved in 1991, provide (effective July 1, 1993) an annual payment of DKK 8000 for children ages 0-6 and DKK 6000 for children ages 7-17. At recent exchange rates, the tax free DKK 8000 0-6 benefit is the equivalent of U.S. $1,328.[7] This would be about 3.4 percent of the gross wage of an average male salary or 4 percent of an average female wage. It is considered a significant sum for families.

There are important supplements to this benefit, also untaxed. The payment for a child in a one-parent household (also paid in a two-parent household where one of the parents has long hospitalization and is unable to work) is increased by DKK 4340 ($720). There is a further allowance of DKK 3320 ($551) if the allowance is the sole source of income of a single custodial parent. Orphans who have lost both parents receive DKK 16,668 annually.

These benefit levels represent something of a recovery. After a brief attempt to use family allowances in the 1930s to counteract a low fertility rate, expenditures remained low. In 1952 Denmark introduced income-tested tax credits for families and children and, under special circumstances, means-tested cash benefits. Flat-rate benefits replaced all of this in 1961. In 1967 a more generous, flat-rate, universal scheme was introduced, but it was then eroded in the decline of expenditures for families and children in the 70s and 80s, while other social expenditures (pensions, health) grew. In 1973 entitlements were severely restricted (to single parents and those below 15) and youth allowances were means tested. Income testing was added in 1977 for all allowances. The results of the recent return to universalism are as described above. The one-child allowance was equal to approximately 3.4 percent of an average gross wage in 1970, 2.8 percent in 1975, and .8 percent in 1980 and has now recovered[8]. The political discussion suggests that the child allowance is currently secure. Of some interest is the fact that despite low fertility and population decline (see below) there has been no effort in recent decades to employ the family benefit for pronatalist purposes.

2. Advance Maintenance.

When noncustodial parents fail to pay child support or pay it late, a government agency (the local social welfare office) advances the payment of a standard child maintenance allowance and attempts to collect subsequently from the parent who owes support. This practice has a long history in Denmark; its roots are found in the mid-18th century. The objective is to protect children in lone-parent families regardless of the parental marital status. In the late 1980s, some 15 percent of all children 0-18 received the payment. These payments are integrated into the family allowance system and are not considered as social (public) assistance. Nor are they considered as income if there is an application for social assistance or a means-tested rent subsidy[9].

The yearly advance maintenance payment per child was DKK 8340 as of July 1993, in two installments, six months in advance, roughly $1,380. (This was about 3.6 percent of an average male wage and 4.3 percent of an average female wage.) This sum is adjusted to changes in the cost of living.

3. Maternity and Parenting Benefits.

As stated earlier, Denmark has not enacted any special schemes favoring family formation. Unlike some countries, it does not offer birth grants. However, as noted below, it has an exemplary program of maternal and child health protection.

Denmark's 1967 flat-rate child allowance legislation included provision for maternity grants, but the latter were withdrawn in 1973 - following 1972 legislation, part of the universal health provision, which extended general coverage for sickness, maternity, childbirth, work injury and adoption at a replacement rate of 90 percent of previous gross earnings (as is the case with unemployment). Present regulations, introduced in 1980 and subsequently revised several times, most recently in 1990, provide for four weeks leave before childbirth, and fourteen weeks thereafter. The mother receives a flat rate taxable cash benefit equivalent to an unemployment insurance benefit of DKK 2638 per week (roughly $438) and the equivalent of 65 percent of the earnings of an average industrial worker. In addition, the father may take leave for two weeks after the child is born or comes home (with similar wage replacement). As the result of collective bargaining, all public sector employees and some private sector workers have 100 percent wage replacement[10]. The eighteen week leave involves job protection. Beyond this, there is entitlement to another six months of parental (either parent) leave at the flat rate of DKK 2110 (about 80 percent of the unemployment benefit. A further six months is available only with employer agreement and the locality may supplement the payment. It may in fact also be used for training or a sabbatical, but the job protection applies only to caring for a child[11].

According to a 1990 survey, half the fathers have taken advantage of the two-week leave but only 3 percent of the final ten weeks. This is attributed to the salaries of the men, which are higher than both women's salaries and the maximum benefit. Thus take-up is affected by the higher opportunity costs and job-site resistance, as well as an increased interest in breast-feeding.[12]

Effort to enact a more extended supplementary parental leave in Denmark, more like what has developed in Finland and Sweden,[13] where long resisted by feminists and others who favored an extension only if it mandated that a significant portion of the time could be used only by men. Nonetheless, the realities of unemployment in the early 1990s overcame the hesitation. Effective 1993 parents with children under age 8 were given the right to a job-protected leave of as long as 52 weeks to care for their children. This leave is paid for out of the unemployment fund and is equal to 80 percent of the maximum unemployment benefit or DKK 132,6000 ($22,000) annually. At the time of the leave-taking there must be an agreement with the employer as to its duration; the vacated position must be filled.

Prior to this enactment, it was common knowledge that many women drew upon unemployment insurance, with its similarly high income-replacement rate, to extend the leave beyond the twenty-four weeks.

In recent years, the proposal has been made several times that the "at-home" option for one parent (clearly the intent is the mother) be equalized with the child care option by allowing the per child expenditure for child care to go "with" the child. This would be similar to Finland's policy.[14] Such proposals have not engendered much public discussion or support. The research shows that mothers want to hold on to their jobs and to be assured of the public child care. However, they find the long work hours difficult and would prefer a shorter work day if possible.[15]

4. Care of A Sick Child.

Denmark does not match those countries with generous benefits permitting care of a sick child. There is no statutory right to such leave, but all public sector and most private sector workers have the right through workplace policies to remain at home with full pay for the first day of a child's illness. What apparently occurs is that the mother remains at home the first day, the grandmother the second, perhaps the father on the third. Then the mother, if needed, will report in sick and use her own sick days for sick child care. This is regarded by some child advocates as an area requiring attention.

On the other hand, a 1990 amendment to Denmark's Social Security Act makes it possible for a parent to stop work to care for a seriously ill child under age 14. The income replacement corresponds to what the parent would have been entitled to as a sickness benefit and may cover fifty-two weeks over eighteen calendar months.

5. Maternal and Child Health.

Denmark's maternal and child health program has long been considered an exemplar. Apart from the excellent infant mortality, maternal mortality, and morbidity results - much of which is attributed to a generally progressive social policy and the related standard of living - the program has been seen as the nucleus of a family supportive health and social service effort, geared to case finding and early intervention.

The maternal and child health program is anchored in the country's general health service. Denmark, as did many central European countries, began with occupation-related sickness insurance schemes. It gradually moved towards universal coverage, finally transferring all responsibility to public authorities. The National Health Security Act of 1971 abolished remaining insurance feature of health protection, dissolved sickness insurance funds and assigned their tasks to public departments. A uniform system of sickness, childbirth, work injury payment was set up on the same basis as unemployment insurance. Medical care, whether outpatient or hospital based, is a public service. The total health budget, all paid out of the tax system, is distributed as follows: sickness benefits, 10 percent; hospital costs, 70 percent; out-patient services, 20 percent.[16]

A family chooses a family physician from among all physicians in its catchment area. If the family moves to another area, it has the option of continuing with its physician. Recent policy allows a physician shift every six months, and even more frequently under some circumstances. The family physician is the route to specialists and hospitals. By all indicators the arrangement enjoys considerable popular support. Denmark does not experience the indiscriminate use of hospital emergency rooms and outpatient clinics known to the U.S.

The Ministry of Health at the national level deals with fourteen county councils plus Copenhagen and Frederiksberg, which serve both as cities and as counties. At the tier below the counties are the 273 municipalities. The counties carry responsibility for out-patient health services, hospitals, special services for the handicapped, and the non-medical training of nurses and occupational therapists. The municipality is responsible for social services (under the Ministry of Social Welfare), which are closely linked with the health services, as well as for nursing homes, shelters, home nursing, and health promotion. In effect the health care of infants, toddlers, and preschoolers to the age of 6/7, when compulsory school begins, is monitored by the public health nurse who has links with the family physician and with the social workers in the local social service departments and by the family's physician. The nurse's role is preeminent in the first year or so for most children; ongoing coverage is by the physician until the child enters school. The school health service takes over when the child enters elementary school, but the public health nurse continues to serve as a special liaison for families when there are special needs.

The public health nurse is far more than the health visitor known in some countries. She completes training as a nurse, is required to have hospital experience, and, then, takes a year of special training. She is an experienced, well-qualified practitioner.

When a child is born, a message reaches the public health nurse through the hospital or midwife. (As is the case in many countries, midwifery is well developed and recognized as essential and effective in Denmark; almost all births take place in hospitals). Mothers tend to remain in the hospital for a week following birth of a first child, less with subsequent children. The public health nurse's first visit occurs during the mother and baby's first week at home. On the first visit, there is much talk about the delivery experience (an opportunity to share and to express anxieties), the child is weighed and examined, the nurse deals with the mother's ability to breast-feed, and gives any necessary guidance. If an alternative is needed, the mother is helped with the formula. There is an emphasis on understanding how the mother and baby are doing together. If there are older children, those relationships are looked at as well. Where problems are noted with regard to the housing a referral will be made; close social service links also exist and facilitate referrals. A handicapped child might be referred for special treatment or equipment. Where special medical treatment seems to be needed, the public health nurse makes contact with the family doctor. The latter in turn has set contact times, when the baby is 1 week old, 5 weeks old, 5 months old, 10 months old, and 15 months old. There are then routine check-ups annually until the child is 6.

Also visiting is the midwife, who will come to the home one or two times in the first week, particularly if the hospital discharge has taken place in fewer than five days. (There is current experimentation with shorter stays, even one-day stays.)

If the public health nurse sees reason for concern about potential or possible neglect or abuse she may discuss it with the family doctor or go to the social welfare office. There are from time to time multidisciplinary meetings at the local social welfare office about cases which are of concern, to develop a course of action. (Few infants are removed from their home for abuse or neglect; support and help is preferred. There is more removal of 5/6 year olds, but the largest group that are separated are teenagers.)

All newborns are covered by the initial visits, although the mother has the right to refuse. The pattern for some time has been to individualize the visiting schedule after that, depending on family circumstances, the mother's experience, the perception of potential problems or needs. Some homes may be visited only two or three times in the course of the first year, particularly mothers having a second or third child. A public health nurse whose caseload at a given moment might be estimated at 140 (not a precise figure) responds not to a formalized schedule (an earlier pattern) but to how the child is developing, whether she is dealing with an isolated single mother, whether the family is part of a social-support network of family and friends, and the mother's health status. The nurse gives extra time as needed. If concerned about a child's care she does quite a lot by way of detailed demonstration; such as, how to bathe a child, how to touch a child, how to give love, how to let feelings show.

Another supportive or educational device emphasized is what the nurse calls her "open house". She invites several mothers with newborns to a gathering in an apartment or office location close to where they live. Here she can talk to the group, look at individual children, create subgroups (immigrants, parents of twins, younger parents) for help on a group basis.

Inevitably, all of this creates a complicated scheduling problem for public health nurses but there is obvious enthusiasm for the role, despite the frequent readjustments as birth frequencies fluctuate and special needs arise. The nurse maintains one office in the municipal public health office and another in the schools where she cooperates as a team member with the doctors. While in theory she has a relationship to day care, day nurseries, and nursery schools, as does the family doctor, the practice of having the public health nurses at these facilities where children are routinely checked was dropped some time ago. The district health officers supervise health practice in the nurseries; they go in on their own, in response to calls from the director, or in response to calls from doctors who have some concerns. Some municipalities expect the public health nurses to give guidance to the child care staff. They also may be invited to speak at parent meetings.

When the child reaches elementary school age, the school health service takes over, but the public health nurse continues to play an important part. The school physician examines kindergarten, first, and second grade children once each year. All routine health care for children beyond the second grade is done by the public health nurse, who sees children annually, tests their sight and hearing, and does health education.

Recent developments in research and analysis of experience have confirmed decisions to move the system of doctor, midwife, and nurse visits to a more individualized pattern, decreasing what were regarded as unnecessary routine visits to some families. The training emphasizes sensitivity to special needs groups: young single mothers, immigrants, people of different cultural backgrounds, the socially isolated. The program features effective interdisciplinary collaboration, family-supportive "early intervention" which is both social and medical, and includes family education on a one-to-one and small-group basis. Staff regard themselves as still working to improve interdisciplinary collaboration and the methods of individualization.

6. Child Care Services.

The two strong facets of Denmark's infant/ toddler policy - as noted - are the child health and the child care services components. Denmark leads Europe in its coverage of child care needs of very young children. In the 1970-81 period, when expenditures on child benefits were reduced by 22 percent, expenditures for day care rose by 148 percent. Because of the great emphasis on child care, cash benefits, which were 63 percent of family expenditures in 1970, had declined to 35 percent by 1981.[17] The cash child benefit policy was driven by national fiscal considerations and political developments. The child care evolution resulted from consumer pressures, more specifically the expressed needs of working parents, at the municipal level. By 1978 the local government share of social welfare expenditures had reached 34 percent. Since 1987 there has been full municipal financing of child care, apart from parental fees. (See Table DK-1)

In 1991, of all expenditures for families and children, services or in-kind grants (56.1 percent) overwhelmed cash allowances (43.9 percent), as seen in Table DK-1. Since general health services are excluded from this calculation, the service component referred to is child care and after-school centers. There is no such expenditure pattern elsewhere in Scandinavia despite a clear tendency in this direction in Finland and especially in Sweden. There is certainly no such pattern elsewhere in Europe.

Behind these data is the recognition that over 90 percent of the mothers of young children are in the labor force, as are almost all parents in two-adult families, and that parents need and expect child care services. Legislation under the Social Security Act in 1976 and subsequent amendments obligate public authorities "to make available the required number of day care facilities for children and young people".[18] Municipalities were assigned responsibility for child care in 1976. By 1989, capping a period of rapid growth which began in the mid-1960s and was particularly intensive between 1985 and 1990, Denmark had achieved publicly provided or subsidized space for more than 59 percent of the 6 month - 2 year cohort. For the 3-6s, it was 75 percent. Table DK-2 shows coverage in centers and supervised family day care by age for 1992:

Table DK-2

Denmark: Child Care Coverage by Age Groups (1992 in Percentages)

Age	Centers	Supervised Family Day Care	TOTAL
0-1[a]	4.7	15.3	20.0
1-2	21.9	37.6	59.5
2-3	30.3	37.2	67.4
3-4	60.0	16.2	76.2
4-5	76.1	4.6	80.8
5-6	76.5	2.9	79.4
6-7	34.4	0.8	35.2

Age	Centers	Supervised Family Day Care	TOTAL
0-2[b]	18.0	41.0	59.0
3-6	61.0	14.0	75.0

[a] Almost all is 6 months to 1 year.
[b] Mostly 6 months to 2 years.
Source: Danmark Statisik, Statistiske Efterretninger, 1993:12, Table 5.

Especially noteworthy, as very unusual, is the relatively small difference, as compared with other countries, between the 6 mos. - 2 yr. coverage and provision for the 3 - 6 cohort. (Mothers are home on maternity leave for the first 6 months). This coverage rate does not mean that 0-2 care (1989) by parents (29 percent), grandparents (8 percent), domestics, etc. (2 percent), and other arrangements (1 percent) (mid-1980s) is not significant. For 0-6s, publicly delivered or supervised care reached 68 percent of the cohort by 1992, according to informed sources, however. A slightly different classification for 1989 reports the following enrollments in the system; as will become clear, Denmark does not follow the common 0-3, 3-6 classification as rigidly as do some countries; (our paraphrasing of program descriptions; we have not included the after-school care for those over age 5):[19]

Community supervised family day care for 0-2s	- 67,302
Day nurseries for 0-2s	- 23,610
Nursery schools (mostly 3-6, specific numbers not provided for under 3s)	- 90,920
Age integrated centers (sub-totals not provided for 0-2s here)	- 50,134

Of the under-3s (6 months - 2 years) in out-of-home care, some 61 percent are in publicly provided or supervised family day care, 23 percent are in day nurseries, 3.1 percent in nursery schools, and some 12 percent are in age-integrated day care.[20] These programs are further described below and illustrated in our ON THE GROUND section.

Although there is some dispute as to the actual size of the authentic waiting list (the estimates ranging from over 30,000, a quite credible total, which could be excessive, to 70,000) there is consensus that more publicly provided facilities are needed and that some of the "parental" care listed above is, in fact, care in non-publicly regulated family day care.

In a recent report for the Ministry of Social Affairs, for submission to an EC project, Vedel-Petersen summarizes the history of the system, current coverage, accomplishments, and public response. He then asks about the research findings as to impact.

First, there are the facts.[21] This day care system, probably the most comprehensive within the EC, is run with considerable public subsidy and

> plays an important role in Danish society, because it releases a large number of women to the labour market, and because it secures a considerable number of families with children two incomes, and single parents the possibility of taking up employment. This provides families with children with a standard of living which they could not otherwise attain.

These programs are both publicly operated and operated by private organizations with public subsidy. All are publicly regulated and supervised. What is more, despite derivations from the usual two historical steams (care for children of the poor so that their parents might work; the kindergarten philosophies of Froebel, Montessori, etc.), Denmark long ago abandoned the distinction between custodial care and an educational (developmental) experience. An effort is made to achieve the same level of quality in all types of facilities, and the same formal standards apply everywhere with regard to staff, equipment, resources. Specifically:

> There is no intention of giving different day care services to different social groups. The social aims of the daycare institutions are integrated with the educational aims.[22]

The facilities for the under 3s and their standards are described by Vedel-Petersen as follows:

- The day nurseries (crèches in the international vocabulary) are for children under age 3. They tend to enroll 30 - 40 children, divided into groups of 10 children and 2 adults. They are open 10-12 hours daily except Saturday, Sunday, and public holidays. There is concern both with care and with the children's personal development.

- Supervised family day care (childminders) is local-authority supervised care in private homes, each with a maximum of 5 children (but 3 besides "own" children is average). It began as a temporary measure, in view of the shortage of center care and the unsatisfactory nature of the informal family day care which was filling the gap. As noted, below, it is now "a firmly established alternative, to which authorities give the same status as institutions [centers], and which many parents of young children consider preferable to the institutional facilities".[23] Legislation enacted in 1990 permits two child minders working together to care for as many as 10 children in their own home or in quarters made available by the municipality, preserving the ratio of one adult to 5 children.
- Nursery schools (kindergartens in the European sense, prekindergartens or nursery schools in U.S.) enroll children from 2-3 up to school age, 6/7. They tend to enroll 20-80 children in groups of 20 children and 2 adults. However, if a nursery school has an infant group, for children under age 3, the prescribed registration is 12 children and 2 adults. Nursery schools are usually open 10-12 hours per day but some are half-time and some include both half-time and full-time groups.
- Age-integrated centers, increasingly popular, may serve children from age 1 to ages 10/12. However, recent developments favor programs for the 0-6 ages. It is held

> that young children benefit from play with slightly older children, that the age range permits the development of activity groups which correspond to children's interests and development - and that these arrangements make it easier for local authorities to cope with fluctuating demand. While the formal adult: child ratio in age-integrated centers is the same as in nursery schools, each child under age 3 is counted as two children in computing adult: child ratios in age-integrated centers.

Virtually all children in day nurseries (99%), nursery schools (94%), and age-integrated programs (93%), attend full-time. On average the under-3s are in care seven and one-half hours daily but over half spend eight hours or more in the facilities.

The individual facilities are governed by committees made up of parents and staff. Legislation in 1991 decreed that parental members be in the majority and that boards have jurisdiction over financial matters, program, and relations with other institutions. They select new staff from among applicants. It is too early to assess the results of this legislation. As is common in most countries, individual parental contacts are most intensive at the time of bringing or picking up their children. Facilities hold parent meetings twice each year and there are active moves under way in the parliament to strengthen the parental role even further.

Child care is in the domain of the municipality and local mayors are quoted as saying that sufficient and good quality services attract enterprises because they attract potential female employees (much as local officials attribute such power to strong local schools in the United States).

Local social service departments establish and operate those child care programs, except for nursery classes and (school-based) after-school programs, which are in the province of school authorities. Social service departments also approve and supervise self-supporting or private facilities. The public authorities administer the allocation of places in public centers and supervised family day care. Individual agreements are made with regard to admission to private facilities. Priority goes (not in any particular order) to children of single mothers, children for whom recommendations are made by medical personnel, children with two working parents, children with siblings in the same facility, children with specific social and developmental needs, handicapped children, immigrant children, socially deprived children.

Most of the non-public facilities are identified with larger organizations which play an advocacy, service, and - often - program development and publication role. Thus, the National Association of Free Kindergartens and Leisure Time Institutions (Landsforeningen Frießørnehaver og Fritidshjem) is an association of 320 of the 1700 child care facilities under voluntary auspices, out of the some 4500 child care facilities in Denmark. It is the largest of such associations and is linked to the trade union and women's movements. Others, for example, many have religious auspices. This association handles payrolls and related financial matters for all associated groups (and is reimbursed by the municipality). Its payroll section makes direct payroll check deposits and does needed accounting. It has an active, indeed impressive, program of program innovation, publication, parent involvement for which it must raise funds. It has 6000 individual, dues-paying members, a high prestige board including leading experts, and enjoys considerable revenue from publication sales.

It might be added that in Copenhagen some 90 percent of all children in the age group from 6 months to 6 years are in child care, and that half of this is in the private sector. Here as throughout Denmark, however, the "public-private" distinctions are very few. All programs are publicly financed and regulated and parents do not perceive significant differences. Nationally, 62 percent of facilities are public and 38 percent private.

Recent efforts to reduce waiting lists have included permission for municipalities to offer per-child grants to parent cooperatives, interest groups, enterprises and others to establish day care schemes. While public supervision is required, the rules are less constricted than for traditional schemes and it is anticipated that this could possibly add to the system's flexibility and diversity.[24]

There is general recognition in Denmark that child-care services are expensive. Vedel-Petersen reports the following actual average annual costs (we have added a U.S. currency equivalent - and purchasing power parities - for 1992 to illustrate the kind of calculation readers may want to keep in mind for all countries [see Appendix]):

Table DK-3

Danish Child Care Average Annual Total Operating Costs

	DKK	U.S. A	U.S. B*
Day nursery,	DKK 79,000	$13,114	$7,979
Family day care,	DKK 43,000	$ 7,138	$4,343
Nursery school,	DKK 42,000	$ 6,972	$4,242

Source: Vedel-Petersen, op. cit., p. 10 and Author Calculations

* Column A at OECD 1992 rate of 1 DKK = $ .166. Column B at PPP 1992 rate of 1 DKK = $ .101.

The average 1992 gross male wage was DKK 232,000; the gross female wage was DKK 196,000.[25] A day nursery place costs the society 18 percent of the wage total in the two-earner family. By public policy, parent fees are not to exceed 30 percent of costs and in fact were 22 percent on average in 1990. Fees are graduated up to an income of DKK 144,900 ($24,053). There is no fee for those who earn less than DKK 46,600 ($7,736). Full fees are paid for those who earn over DKK 144,900. An average two-earner income family in the full fee category would be spending about 5.3 percent of gross income for one child for day nursery care, 4.8 percent for family day care, and 3.5 percent for nursery schools. If there is more than one child in the family, there is a 33 percent fee reduction for each. Swedish parents pay relatively higher day care fees.[26]

Priorities and high overall registrations not withstanding, high-income groups use child care more than low-income groups. There is more full-time work by better-educated women and more part-time work by the less-skilled and less-educated. "Only" children are more likely to be in care than are children in two or three- child families. Single mothers (88 percent) use child care more than married (68 percent) and cohabiting (72 percent) mothers. Mothers who work less than twenty hours place children in care less than mothers who work longer hours or full time. While about 90 percent of mothers work, about one-third of these, a decreasing portion, work part-time. Mothers with white-collar job status turn to child care more often than blue-collar workers and the self-employed.[27]

The majority of professional staff in public group child care facilities have three-year, post secondary, specialized training. Salaries are at about the level of average female wages in Denmark and staffs are quite stable (and turnover about 10 percent a year). It is considered a good job. As of late 1991, a reorganization consolidated college-level courses for personnel to work in day nurseries (crèches) with courses for personnel to work with handicapped children and in kindergartens (nursery schools). There is some expectation of greater efficiency based on shared core training and specialized add-ons.

The overall staff coverage ratios (personnel working directly with children), if one computes on the basis of national data, are one adult per 3.2 children for the day nurseries (children 0-3) and 1 per 6.3 for the nursery schools (2/3 - 6/7).

In the day nurseries at the height of the day's activities, the coverage is three to four adults per group of ten to twelve. One of these adults would be a fully qualified child care worker and one would be an "assistant". In many nursery schools, with three adults for twenty, one would be a fully qualified nursery school teacher. Additional staff are added where there are handicapped children, children speaking a foreign language, etc. In age-integrated centers, on average one adult works directly with 5.8 children. The family day care standard allow no more than five children per adult; local authorities set qualifications. Despite this, Vedel-Petersen holds that "the children's activities and the educational opportunities [in family day care] do not differ much from those of the nurseries."[28]

According to Langsted and Sommer the family day care mothers in most municipalities have a two to three week training course before assignment. Participation in a larger array of courses is voluntary. There are six-week basic and supplementary courses. These courses focus on children's needs and development, the child's relationships in the family, the family day care staff's relationship with children's parents.[29] Some family day care mothers elect the longer and more intensive courses. All have the support, guidance, and supervision of a well-qualified local authority staff member who has completed the "pedagogic" training and is experienced.

While there are few programmatic specifics in social legislation, there is no debate with regard to the assignment handed to these programs: in cooperation with parents and children they are to promote child development, well-being and self reliance. In earlier years, staffs tended to be more "liberal" (permissive) than many of the parents, but this is said no longer to be the case given cultural changes affecting both parties. There is little formal instruction, competition, or stress on achievement in these programs. In Vedel-Petersen's terms, referring both to the under 3s and the 3-6s, "the emphasis is on self-expressive games, on the role of the imagination and on creative activities, on the attainment of social maturity through group activities, on linguistic development and on overall stimulation of the children with the help of a wide range of materials and activities."[30]

Along similar lines, Langsted and Sommer stress that despite the high rates of participation, "there is no indication of a society that would encourage the State to take over the socialization of the child or replace the family. Instead there is a moderate 'cooperative' and 'supplemental' view of public day care. ... The Danish public day care system is known for its great diversity when it comes to the pedagogic content and the planning and administration of the concrete child rearing process. These specific aspects of the day care provision are, to a large degree, handed over to the *pedagogues* of individual institutions in cooperation with the parents."[31] In the latter context they note that the term "pedagogical" here connotes "a primarily developmental perspective on the psychological and social development of children ."[32]

A high official in the Ministry of Social Affairs confirms these views and states that the caretakers are called "pedagogues", not "teachers", to make an important distinction. They work with children without writing curricula and programs for every day. The children are offered activity choices when they enter the program in the morning, and the "pedagogues" are trained to respond to their leads, give them success, and let them develop skills. The child care is highly individualized.[33]

What is known about impacts? The parents clearly are pleased. Some 95 percent prefer their arrangements as compared with alternatives. But rigorous measurement of impacts is not easy in a milieu in which much else is occurring to and in families and neighborhoods and in which random assignment to experimental groups is not considered. Nor are outcome measures easily agreed upon or developed. Vedel-Petersen sums up the modest amount of Danish research. (There are few demands for proof of efficacy - the society only debates costs of these programs, which are considered to be necessary). He looks as well at other research in Scandinavia and elsewhere in the world. His conclusions are put modestly and tentatively.[34]

Vedel-Petersen begins by dismissing those concerns reported elsewhere about "institutions with poor staffing levels and inadequate equipment ... such institutions are only justified in areas where the children would otherwise be neglected." These concerns do not apply to Denmark where "high and cost-intensive demands are made".[35] On the other hand, he summarizes research which concludes that illness rates for children cared for in day care centers is higher than for children cared for in family day care or at home. Although the number of infections declines with age from 10 months to 4 years, the differences based on modes of care do not decline. The rate of infections is a function of the numbers of children to which the child is exposed. Although there is no definitive evidence presented, the major Danish investigation of these matters does not believe that there is truth in the widely repeated notion that early exposures to "trivial virus infections gives greater resistance to infection in the longer term". The research derives its data from parental reports. It may be that parents of children in center care are more alert to all infections - because they are more disruptive than if the child is at home. Nonetheless some observers see here a case for somewhat longer parental leaves and for provision for parental time to care for sick children.

Generally reassuring to Scandinavian experts is the research of Erik Bengt-Andersson which followed several groups of children longitudinally from infancy up to elementary school age and compared them on the basis of various tests and teacher observations/ evaluations. Comparing early starters in day care centers with those in family day care, home care, and those experiencing shifts in types of care, the research found distinct advantages by age 8 for the early day care center starters. Positive differences were found in language and all school subjects except gymnastics. (The groups other than the early starters in centers do not display clear differences.) In the teachers' view the early starters are more outspoken, less anxious in school situations and more self-expressive. They are more persevering, more independent, more inclined to express their opinions. While not all differences are statistically significant, the trend is clear. More recent follow up shows visible positive results even at age 13.[36]

What, then are the reservations here? Only that complex issues cannot be definitively settled by one study, and that the debate about care of infants persists in a number of countries and in the research literature. Of course when Danes discuss infant care they mean "after age 6 months", given the maternity leave - something not the case necessarily in the U.S. Vedel-Petersen cites those Western studies that raise questions about attachment, linguistic development, and tendencies to aggressive behavior, recognizing that research questions have been raised in each instance and that it is uncertain that some of the patterns found are in fact negative. The evidence suggests, too, that the early day care experience for infants either promotes intellectual development positively or - if one looks elsewhere - certainly is not harmful.

While much may be open, Vedel-Petersen's strongest negative conclusion is that infant/toddler care, while it does not seem to have permanent long term negative results and would appear to have some positive consequences, is not without a price. There is some impact on the child's "immediate quality of life" which "cannot be overlooked entirely". Here he refers to the research showing early negative reactions to the separation experience (which the children in one study sustained for five to seven weeks), difficulty in settling down under some arrangements for some children, and some tendency for brief and superficial contacts with other children in centers. A senior government official, without citing data, says that he does not believe these can be indefinite continuation of a pattern in which way young children, from age 6 months, may be spending eight to ten hours a day in child care centers, are tired at the end of the day, and are picked up by two parents who have worked full time and are also tired. While he says that there may be no real evidence of harm, he cites a general feeling among health visitors and child care professionals that it cannot be good - and that young parents have become confused about their roles. One consequence is the effort of child care staffs to construct parental support systems (see below).

Langsted disputes such conclusions from his study of 5-year-olds.[37] The quality of life, he holds, is a function not of the number of hours worked but of what parents do with and for children. He describes how well parental schedules are developed to share the "drop off" and "pick up" functions. Parents and children are not found to be as tired as alleged. In objective studies high scores for parental relationships with children and quality of family life are found in families with two parents working full time.

Here Vedel-Petersen reports study results favorable to high quality family day care, where children "had far more frequent and richer contact with other children" since the older children played with the younger ones. It also has been found that "family day care mothers pay greater attention to and have a better understanding of the child's individuality than staff in nurseries, and family day care mothers generally appear to stimulate the child's experience of its own identify more than institutions. In institutions on the other hand, there is more play aimed at developing skills than in family day care."[38] In general, family day care research finds that those children are more like home-reared children, not displaying the major positive and/or the debated negative results of infant/ toddler experience in centers. What stands out is that the family day care experience is more personalized.

In the context of general parental satisfaction with care arrangements and support of publicly arranged care (and the small demand for a full-time extended at-home arrangement for parents) one notes some preference for family day care and for a shorter work day, to shorten the care day. A case is made for longer maternity/ parental leaves. And there is support for sickness leave. The research, then, is seen as supporting these directions, perhaps, but not as justifying a fundamental turn in direction. There also is a call for more research into optimal length of the care day, center programs, the uses of center care and family day care, and of age-integrated schemes.[39] In the meantime, day care policy is described as a pragmatic solution allowing families choice of lifestyles, contributing effectively to a reorientation of family life at a higher (two-income) standard of living. Any shortage of facilities can be overcome over the next several years.

Our vignettes and report of how the programs and policy specifics play out, as seen in several municipalities, appear in the ON THE GROUND section. We also reserve for that section a report on the current strong preference among Danish child care leaders for age-integrated programs (defined in several different ways).

7. Parent Education and Family Support.

Unlike, for example, the developments in central and north Italy, Denmark has not gone very far in these directions. However, commenting on the strain felt by young parents who place their small children in eight to ten hours of care at a very early age, and both of whom are very tired as they pick up a tired child at the end of the work-day, a top public officials see the movement in child care centers for family support as a response.[40] Some municipal child care centers have been organizing weekly dinners for parents and their children, in part to encourage a parenting network or parent self-help group. The dinners are very popular. The fees are modest and subsidized. The new parent activities include keeping the center play areas open on Saturdays and Sundays, trips for parents with children to nature centers, and similar activities. (There are similar initiatives in elementary schools.)

In short, the health visiting activity already described and these child care enhancements represent the major and a most impressive Danish early intervention, parent education and family support activities affecting families with young children. At another level the schools have extensive provision for health and sex education built into the regular educational program, with details specified by local school boards. Sex education ceased to be controversial twenty or thirty years ago.[41] The sex education includes, for appropriate grades, general information about contraception. General practitioners also provide information and supplies.

Denmark's social work, counseling, and psychology programs offer divorce counseling (largely private), child and youth guidance (county), general and anonymous counseling (local). There are many self-help groups and movements similar to the range in the United States. Especially well developed are extensive telephone counseling services and "hot lines", targeted at children and young people.[42] Another counseling service (on Sunday mornings) offers telephone responses by midwifes, health visitors, nurses, doctors and psychologists to questions about the periods before, during, and after childbirth.

CONTEXT

1. Demography and Social Trends.

Danish scholars have documented the enormous changes in the society, especially over the past twenty-five years, which have converted most families to the two-earner pattern.[43] In contrast to the past, they hold, it is no longer the case that the primary locus of socialization for children under age 6 is in the home. Currently, almost from the beginning of the child's life, socialization is shared between home and societal institutions in a pattern which some scholars now call "dual socialization".

There is a debate in interpreting this, however, with some arguing that the salience of the parental role is not diminished by this sharing. Langsted and Sommer comment, for example, that young children "must act within the frameworks of time, the social and physical space which the adults, acting as structuring agents, construct for them."[44] There would be consensus that this is hardly a new or modern development. The issue remains whether major parental prerogatives are ceded to institutions other than the family.

The context is the high rate of female labor force participation and various changes in family structure and demography. With regard to the former, describing Denmark's change from an agricultural to a high-tech, well-educated, modern, post-industrial (information and service) society, Langsted and Sommer note that:

> In the 1950s, mothers remained at home and cared for children.
>
> In the 1960s, women began to work outside the home but they interrupted for the pre-school years.
>
> In the 1970s, many more women were employed outside the home but they interrupted or worked part-time while the children were very young.
>
> In the 1980s and early 1990s almost all mothers of children 0-6 are in the labor force and many more than previously are working full time and keeping their jobs while their children are young. Moreover, the mothers of the youngest children work the longest hours.[45]

To which we added that proportionately more mothers of children ages 0-6 are in full-time work than mothers of children ages 7-14. The mothers of the youngest children are heavily engaged in establishing themselves in the labor market and, simultaneously, in a home/housekeeping situation.[46]

Denmark (see Appendix Table) has one of the highest female labor force participation rates (77.3 percent in 1989) among all Western European countries, exceeded only by Sweden (80.5 percent) and Finland. It is unmatched with regard to participation in the labor force of women with children under age 3 (83.9 percent) (1986) and lone mothers with children under age 3 (80.9 percent).[47] Within the E.C., only Denmark reports that women make up half the working population (1988). In France, women are 41.6 percent of the labor force. The percentages are considerably lower in the other countries. On the other hand, Denmark is generally high in part-time employment and leads, Sweden apart, in part-time female employment (41.9 percent).[48]

With over 90 percent of the prime-age mothers of the 1/2-6s in the labor force (1989), and full-time defined as thirty-eight hours a week, fathers, on average, work forty-two hours and mothers thirty-four. The regional variations are minor. Surveys by the Danish National Institute for Social Research consistently report that these mothers do not want to give up their work but 80 percent would prefer a reduction in work hours. A 1987 survey reported in Langsted and Sommer documents a major preference for a pattern in which both fathers and mothers worked part time and children were in child care part time (46 percent); or fathers worked full time, mothers part time, and children were in care part time (33 percent). Some 11 percent favored the at-home option for mother and child, with the father working full time.

Denmark's population grew from 4.045 million in 1950 to 5.122 million in 1980 and 5.132 million in 1989. The under-18 child population is 1.1 million. There are 390,000 in the range 0-6, a fall of close to 100,000 in one decade.[49] A birth cohort in the 1960s was about 85,000; in the mid-1980s it was down to 55,000.[50] There were 61,407 live births in 1989 and 64,358 in 1991 in Denmark, compared with 63,388 in Finland and 115,924 in Sweden.[51] By the late 1980s, the lower birth rates produced in Denmark, as in most advanced industrial societies, a rapidly aging society, with the attendant decrease in the relative size of the child population. However, since the numbers of children decreased while the elderly increased, the total dependency ratio did not change much. As in other Nordic countries, nonetheless, young children are at an all-time low as a percentage of the population.

The overall demographic picture is familiar for all the countries in the study. By the 1980s using E.C. comparisons, Denmark had: the smallest households in the E.C. (2.4 in 1980, as compared with 3.1 in 1950); more only-child families, yet all but 15-20 percent of children have at least one sibling, if very few have 2 or more; a somewhat increasing net marriage rate, after being lowest in EC in 1980; a relatively high percentage of never-married women; the highest average age of women at first marriages (26.8 in 1986); the highest divorce rate except for

U.K. (1987: about 44 percent of current marriages end in divorce); the highest out-of-wedlock birth rates (except for Sweden). In the late 1980s, half of Danish young adults lived in consensual unions and almost 90 percent cohabited at some point but the duration or stability of such unions is unreported. Many cohabiting couples marry later. However, what is relevant here is that a greater proportion of women become mothers than ever before and that virtually all newborns live together with their fathers and mothers. And, as noted earlier, social policy avoids penalizing or limiting adults or children in relation to family forms or the parental legal status at childbirth.

Denmark has had one of West Europe's lowest fertility patterns, as far back as the 1970s. In 1975, only Luxembourg, Belgium, and Germany had lower rates. In 1980 only Luxembourg was lower. By 1981 Denmark had the lowest West European fertility. It remained lowest in 1982-3-4, and then, as the fall in fertility moved further south in Europe, Denmark and other countries in the north increased their fertility slightly.[52] Similarly, other European countries developed lower marriage rates while Denmark increased a bit. By this time, however, Denmark had faced the prospect of a population decline without either demographic anxiety or a pro-natalist response. Its abortion rate currently leads West Europe.[53]

Jørgensen, citing Plovsing, sums up as follows: The number of cohabiting couples has doubled over the past ten years. Of all "partnerships", married couples make up 80 percent and cohabiting couples about 20 percent. It is among families with young children that the proportion of cohabiting couples has increased (now one of four, with 45 percent of children born out of wedlock). Divorce rates doubled between 1965 and 1985; the rate is 30 percent for 1970 marriages (well below the comparable U.S. figure). Of children under age 18, 78 percent live with both natural parents, 11 percent with a single parent, and 11 percent in a new family with a step-parent.[54]

In U.S. terms (and, for that matter, compared to Switzerland and Germany), Denmark's percentage of foreign nationals is low. However, even as we write, Europe is experiencing substantial movements of legal and illegal immigrants and refugees. The inauguration of the unified EC labor market on January 1, 1993 eventually will bring about major changes. The most recently available analysis reports for 1989 some 142,000 foreigners residing in Denmark of whom 22,977 are from other Nordic countries, 26,568 from other EC countries and 92,471 from countries outside the EC area.[55] There are few systematic studies available but it would appear that immigrant children under the age of 6, especially those from Turkey and Pakistan, are less likely to be in child care than Danish children.[56] The under-3 children of arrivals in the last five years are mostly at home, but half of the 3-6s are in kindergartens (nursery schools). Yugoslav and Vietnamese women are said to be somewhat more assimilated and want their children to learn Danish and to succeed in school. The formal policies are receptive and there is some effort made in the training of *pedagogues* to be responsive to ethnic diversity. Vedel-Petersen describes "intensive work ... to find the best work methods and to organize cooperation with specialists and interpreters" to meet the needs of foreign-language children and other children with special needs.[57] One party of the right has attacked foreigners, but the dominant public norm is that Denmark should meet its "obligations". As is the case in much of Europe, recently strains have appeared and the political debate about refugees and immigrants has intensified, especially with an increase in unemployment.

2. Expenditures.

The period 1960-75, the expansion era before the effects of the first oil shock were felt, was a time of growth in overall government expenditures in the OECD countries, and related expansion in social expenditures as well. Denmark, one of the countries with high government expenditures in the period, had a similar rank for social expenditures as a percent of GDP and of total governmental expenditures.[58] Moreover, in 1984, its family cash transfer payments for children under age 15 were (with the payments in France, the leader, and Austria) among the top three in purchasing power parities among the nineteen countries reporting. The real annual growth of these benefits in Denmark had exceeded OECD averages by far in 1960-73, leading all countries in growth rates, but then lagged, not in benefit levels but in further growth, from 1973-84. By 1984, Denmark was spending 4 percent of GDP for cash family benefits, down from 4.3 percent in 1975 and 1980. Family benefits declined as a percentage of social expenditures between 1975-84 at about the rate it had increased between 1960-75. At the same time: public expenditures on health in Denmark consumed a slightly smaller share of GDP, while the OECD average went up modestly; education expenditures held firm, placing Denmark right after Sweden in the European lead in 1975/85, after it had been the leading country in 1980; and public pension expenditures in 1985 showed an increase from 1975 but a decline from 1980. Denmark pension expenditures as a percent of GDP lagged a bit behind OECD averages. In absolute sums and in social expenditure program shares, family benefit expenditures lagged behind health, education and pensions here as in all OECD countries.[59]

When general social expenditure growth rates slowed in most OECD countries between 1975-85, the "tough years", Denmark remained among the growth leaders. If one examines real family benefits per child in this period, Denmark shows growth until 1982, while the other growth leaders had slowed down by 1980. Therefore, as noted above, the favorable 1984 showing in Danish family transfer values at purchasing power parities.[60]

In this period 1960-75 and 1975-88 Denmark had sustained declines in its under-15 population and increases in the over 65s, but a decomposition analysis by Johansen (1988) found that eligibility factors accounted for more of the pension growth than did demography, as benefit levels did for the child allowance decline. Critical, however, to the Danish child policy picture is the further point that whereas cash benefits declined by 22 percent from 1970-81, expenditures on family services rose 148 percent. Cash benefits were 63 percent of Danish family expenditures in 1970 and only 35 percent in 1981. Indeed, so important are service expenditures in the Danish (and Nordic) family expenditure picture as to raise questions about the entire analysis limited to cash benefits. As noted in Tables 1 and 4, child care expenditures alone outweighed cash family benefits in Denmark. Services overwhelm cash benefits in Denmark, approach them in Sweden, are close in Finland, and are outweighed in Norway.

EUROSTAT data for 1989 permit an update for the EC. Denmark remained one of the six Community countries with above-average social protection expenditures, as all grew closer to the average. In constant prices, its overall growth rate was below the Community average as earlier laggards spurted, but, again, Denmark was one of three E.C. countries which exceeded average growth in expenditures for family benefits and maternity protection, while all other EC countries experienced a drop in the share of these expenditures in their social protection budgets.[61] In 1990, Denmark led the European Community in its family benefits as a percentage of GDP, according to EUROSTAT reports. It followed Sweden as did the other Nordic countries (See Table DK-4).

Finally, within the Nordic countries, as in all of western Europe, Denmark is unique in the small role of employer and employee contributory taxes in financing social expenditure costs and in the extraordinarily high portion of costs of the substantial entitlements which are met by local authorities which get half of their funds from the national government.[62]

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Table DK-4

Expenditures for Family Benefits in Nordic Countries, 1978-90, In Percentages of Total Social Expenditures and as a Percentage of the Gross National Product [a]

	Denmark	Finland	Norway	Sweden
Family Benefits as a Percentage of Social Expenditures				
1978	10.7	12.6	8.6	12.5
1981	10.6	13.3	12.3	11.5
1984	10.2	14.5	11.5	11.8
1987	11.9	14.6	11.6	12.1
1990	11.9	13.8	11.9	14.5
Family Benefits as a Percent of Gross Domestic Product				
1978	2.8	2.8	1.9	3.9
1981	3.2	2.9	2.7	3.9
1984	2.9	3.1	2.5	3.9
1987	3.3	3.8	3.1	4.2
1990	3.5	3.5	3.5	5.1
1987 Family Benefits in Millions of Kronor or Finmarks				
Cash benefits (total)	9,451	6,482	11,183	23,324
Maternity	3,050	2,234	2,541	8,294
Child allowance	4,866	2,795	6,270	10,099
Services (total)	13,307	5,542	3,936	19,397
Child Care	9,486	4,497	2,676	18,879
Tax allowances	---	2,852	1,950	---
Currency units per $1 U.S. (1987)	6.838	4.396	6.737	6.34

Source: Adapted from Tables 8.1.1 and 8.2.1 in Rita Knudsen, Familieydelster i Norden 1989 (Stockholm: Norstedts Tryckeni, 1990). 1990 Data from Social Security in Nordic Countries, Tables 3.1.6 and 3.1.7.

3. The Political and Economic Forces.

When the social reform wave reached Denmark in the 1890s, two evolving traditions were joined and compromised, according to Johansen.[63] First, there were the humanitarianism of the Enlightenment and the Mercantilist commitments: the state in an active role to achieve economic growth and prosperity. Then, there were the earlier nineteenth century laissez-faire views ("liberalism") of early capitalism, focused on the incentives of a free labor market, and thus, distinguishing the "deserving" from the "undeserving" and retaining stigma and loss of civil rights for the latter. By late in the century, political and economic realities (as agriculture "industrialized" after a crisis) created a base in the peasantry for more humanitarian reform supported as well by "a unique combination of small-holders and urban intellectuals - particularly teachers". The action taken thus merged views of those favoring "help-to-self-help" voluntarism and limited state responsibility with more active state social protection (social welfare) initiatives and humanitarian values. The early legislation was in a sense a transition package, as it settled issues of scope, form, and financing of poor relief, old age relief, sickness insurance, accident insurance, and unemployment insurance.[64] The Danish precedents came before Bismarck, even though the actual enactments, between 1891 and 1907, awaited resolution of other political struggles over the form of government and defence.

These enactments were little changed until the 1930s, except for the shift in the 1920s of the discretionary old age pensions to a rights basis. In the 1930s the entire system was rationalized and simplified and most poor relief disabilities were ended. Since World War II, the institutional base of the Danish welfare state has been clarified and, while some "market" elements remain (private pension and saving schemes and housing), the main emphasis has been on social entitlement and universalism. The concepts of "undeserving poor" and loss of rights under social assistance are gone. Indeed, in comparative perspective Danish social assistance is generous, allowing a viable lifestyle, as does the treatment of single mothers. By now, almost all means tests are gone.[65]

To illustrate: sickness funds are state subsidized and there are no qualifying conditions for eligibility; old age and invalidity (disability) pensions are flat rate and all insurance features have been removed; tax credits were dropped in favor of flat rate family or child benefits; cash benefits were indexed in the 1960s. Also in the 1960s the supply of social services exploded: schools, hospitals, various agencies and programs, and in the 1970s they were joined with income maintenance programs in a unified "social security" system.

While Denmark has had "an unprecedented welfare state development since World War II",[66] shaped both by solideristic values and economic growth, economic pressures in the 1970s and 1980s led to some of the setbacks already noted: the end of lump sum maternity benefits, some income testing of child allowances and some later retrenchments. Nonetheless, unlike most of Scandinavia, most Danish cash benefits remain flat rate and most programs are non-contributory. Unemployment insurance, too, is generous and liberal (with less emphasis on active employment policy - retraining, geographic mobility, job creation - than in Sweden). The country has little, if any, poverty in the U.S. sense although there is recognition of and response to disadvantaged groups who have a more difficult life.

While demographic change and short term economic growth and decline have only minor impact on major social expenditures, they are significant. Impacts are mediated by the political system, however. Johansen argues that one can identify three processes in social policy;

- "party-competitive policy making" (as in income maintenance and tax policy);
- "corporatist, policy making" (as in unemployment insurance, occupational pensions, accident insurance - where labor/ employer compromises work well);
- "professional bureaucratic policy making" (especially in the social services where most issues do not attract public attention - but see child care as a currently visible public issue!)[67]

From World War II to the 1970s there was considerable consensus and frequent unanimity on social policy in the parliament. Then, in an "electoral earthquake" the Glistrup anti-tax movement, which was to have world-wide influence, created political conflict over many matters. There was some "welfare backlash" and an attempt to curtail growth. However, although Denmark's rate of expenditure growth slowed down considerably, its welfare state successfully survived the economic stagnation and political turmoil of the 1970s. It was doing very well, comparatively, by the mid-1980s, only to enter a period of economic crisis from 1987-1989. Currently, as we write, the Economist reports that Denmark has boasted that it has Europe's strongest economy (tight fiscal policy, constrained government expenditure, wage moderation by trade unions, a fixed exchange rate anchored in the E.C. system). Prior to the currency exchange crisis in the E.C. in September, 1992, only Denmark, France, and Luxembourg had achieved the stated macroeconomic and microeconomic prerequisites for Europe's planned economic union. However, the Economist adds: "Denmark is no European tiger. Its generous social-welfare and unemployment-benefit system probably ensure that it will never become one."

All of this, it should be noted, is in a polity which since 1982 has had coalition cabinets with conservative prime ministers even though the Social Democrats remain the single largest party.[68] According to T. Knudsen, there has been a remarkable willingness to compromise in a very viable system of "consensual democracy" throughout the twentieth century.[69]

Party politics, then, do matter but in the framework of a broad consensus on the welfare state. Indeed, in recent years, adherents of the more conservative parties, have expressed new opposition to further social expenditures, and polarization could be increasing. Some groups favor libertarian policies; while they remain small, they are growing. The child policy components here outlined appear to be firmly anchored. It is noted, for example, that whereas central government can (and has) curtailed child allowances, child care programs result from hundreds of decentralized decisions, influenced by parents and providers and able to resist central calls for restraint.

A variety of public and public-private commissions and legislative committees, very much in the corporatist consensus mode, reflecting interest groups, political parties, and government have produced reports in recent years urging improved child policy. The child's legal status has been improved by legislation. When in April 1991 some funds became available, the parliamentary compromises produced a "child package" which: strengthened child care by limiting fees,[70] and creating a higher income ceiling for free child care,[71] increased child allowances for infants and toddlers, and required that day care boards be chosen by parents. Analysts predict more attention in the near future to the situation of parents with young children (perhaps better benefits for the care of ill children, support for shorter work days, and somewhat more extended parental leaves, at least a year).

ON THE GROUND

1. Child Care

As already noted Danish parents need and expect child care services; given labor force participation rates, this is hardly a surprise. Moreover, to the extent that the work - family - child routine is considered somewhat difficult, the only widely advanced solution is a slightly shorter work day and, therefore, child care day.

In the meantime, Denmark leads West Europe in child care coverage for the under 3s (60+ percent of those aged 6 months to 2 years; most participation starts at 6 - 9 - 12 months, given parental leave) and has outstanding quality in both the 0-3 and the 3-6 facilities. Staffing and group-size standards are high by international standards and parents are by all indications pleased with the care. Recent national legislation gives parent representatives even greater power than previously (majority votes) on center boards.

While the decentralized municipal system allows for diversity, there is an identifiable and distinctive philosophic and programmatic thrust in the Danish facilities. Staff, known as "pedagogues", have a developmental perspective on children, focused on the psychological and the social. They do not develop a curriculum or a daily program, striving instead to respond to the leads offered by children daily to "give them success and let them develop skills." This is true both in family day care, a valued part of the total system, and in group care. Age-integrated groups are now preferred as important to learning, modeling, socialization. In some ways, according to some observers, all of this may be compensating as well for the tightly scheduled and organized lives of children with two full-time working parents.

The under-3s, our special focus, may be found in family day care (61 percent of those in care), day nurseries (23 percent, crèches in the international vocabulary), nursery schools (3.1 percent, kindergartens in the European usage), age-integrated day care (12 percent). In fact, community supervised day care for the 0-2s and the day nurseries have almost the same capacity as the nursery schools. Most children in the age-integrated centers are pre-schoolers and most in family day care are infants and toddlers.

We offer several vignettes, supplemented by comments on staffing, training, parent participation, and - most of all - philosophy and milieu.

To begin with some generalizations: Denmark has splendid child care. By this we mean not only do the Danes have a larger supply of child care for children under age three than any other of the Western industrialized countries but they also have quality as high as what we have seen anywhere. Having said this, however, we are struck by the general philosophical/ideological positions with regard to the program content. There is limited formal structure within the child care programs and a great emphasis on the value of looseness, flexibility and lack of structure. The concept is that this reinforces the child's own creativity, independence, self-reliance, and also compensates for the extensive structure that's often imposed by working parents at home. The general feeling is that children with two working parents often have all of their daytime activities organized and what they really miss is time to just "hang out." In effect the Danes have institutionalized this concept by making it possible for children to "hang out" in their child care programs.

Although the child care programs in fact do have a basic structure with regard to opening and closing times, time of breakfast, lunch, afternoon snack, nap time, nonetheless there is no formal curriculum. There is great emphasis on creativity and giving the child an opportunity to develop its own pattern of activities. *Pedagogues* are expected to pick up children's cues. However, there is great emphasis on the use of the outdoors and a very deliberate effort at having young babies sleep outdoors, and children playing outdoors regardless of the weather.

There is also enormous emphasis on sibling groups (age-integrated groups) and a general conviction that this is how child care programs should go.[72] Here they are mostly talking about sibling groups for children from about the age of 6 months to 6 years, the concept being that this is the "forum" in which children have either their own siblings or other children who function as surrogate siblings for them. It's more like a family situation, and older children learn by helping the younger. It avoids the transfers at age 3.

Age integration began early in the 1970s. It prevails in 30 percent of all facilities, serving 37 percent of the children in care (not including after-school programs). Yet it is a concept still being worked out. One sees different versions in action in different cities (in Copenhagen and Aarhus, for example) and in different program forms. There are large groups of young children, ages 6 months to 2, in day nurseries (crèches in the international vocabulary) but there are some under age 3 in nursery schools, which enroll children from about 2 to school age, 6 or 7 (in the international vocabulary, kindergarten or prekindergarten). So-called age integrated centers have grown in popularity, some serving children from age 1 to 10 or 11. However, recent developments favor programs for all those under 6 and we encountered considerable preferences along these lines. It was said that young children benefit from play with slightly older children, and that the age range permits the organization of activity groups that correspond to children's interests and development. It was also noted that these arrangements make it easier for authorities to cope with fluctuating demand, as birth cohort sizes fluctuate.

To protect staffing ratios, as noted, age-integrated centers count each child under age 3 as the equivalent of two children.

In sketching how some of this looks in action, we would note, first, that the lack of a formal "curriculum" does not mean disorganization. Child care programs have a basic structure with regard to opening and closing times; times for breakfast, lunch, and snacks; nap times. An observer finds children and adults engaged in interaction, as are children with children. There is involvement with materials and activities. The settings are warm, safe, very attractive, stimulating. No one is lost in a crowd. In any comparative context, or on its own terms, this indeed is splendid child care.

Child Care in Hvidovre

The community is a working-class suburban community just outside of Copenhagen. Three child care facilities have been built in a cluster arrangement, two separate day nurseries (crèches, day care centers) for children under 3 and one age-integrated center which includes one group of under-3s. Two are on one side of the street and the third across the street, in a sort of mini child-care park. Individual centers are deliberately kept small and administratively separated. Thus the two "under-3" programs have forty children each, while the age-integrated center, with sixty children, has one group of ten under-3s.

All three centers are in one-story u-shaped buildings with a small, paved, inner-courtyard and a surrounding large grass area (except for the paved entrance). (These buildings, constructed within the past five years, are designed for possible conversion to nursing home or old-age facility use should the demand for child care decrease.) One of the three has a large paved area for some play. Although the general ambiance is urban, two of the centers have vegetable gardens to teach children about planting, growing, and so forth - and to provide food. The age-integrated center has decided to add chickens and rabbits. Despite the cold climate, the grounds are extensive, the equipment good, and the children are out of doors a good deal of the time.

All three facilities open at 6:00 in the morning and all close at 5:00 in the afternoon. They are open twelve months each year, closed for only a few major holidays. These facilities are publicly operated; staff are municipality employees. A *pedagogue* with six years of post-degree experience was earning $32,640, about an average salary for a female production worker. Her monthly $2,720 gross was reduced to $1,530 net by taxes. The director earned about $3,230 monthly, elementary school teachers not much more. A bank teller would begin with a lower salary but would soon be earning more than this "average" salary for women. An aide, with only a high school diploma, would earn about $2,040 monthly and would not be expected to remain in this transitional job more than a year or two.

We visited two of the three centers and found two men on staff. A third had been placed by the employment office as part of a six month placement for long-term unemployed. The latter was a valuable helper, cleaning and rearranging one room, then sensitively feeding an infant. The two men on staff seemed fully integrated into the program.

The staff atmosphere is collegial. The two community higher-level *pedagogues* who serve as inspectors visit to consult on program or child questions but do not formally inspect. The directors have little hierarchical control, but we met a number who were charismatic leaders and were obviously influential. The cooks are hired for individual qualifications and are not expected to have specific formal training.

In these three centers the fees are about $203 monthly for the under-3s, including meals. For the over-3s, who may have breakfasts and snacks but bring boxed lunches, the monthly fee is $150. A family with two or more children in care pays lower fees for the additional children.

We illustrate with "Circus Grounds", one of the day nurseries for under-3s, serving forty neighborhood children ranging in-age from 7 months to age 3. Actually, one is 7 months old, one 8 and the remainder are age 1 or more.

As one enters, there are two shed-like rooms on the side, one for strollers left by parents that morning or for center strollers used to take children on a "walk". The other shed protects staff bikes from the weather. The entry hallway is small; a basket holds a few items of children's clothing which have been forgotten. There is space to hang wet garments and line up boots, essential in this climate. Then one enters the large room, the core of the facility. In a Danish equivalent of the Italian "piazza" (see Italy chpater), this community meeting place and activity center is larger in some facilities and smaller in others (varying even among these three in close proximity) and leads to the group "home" rooms, two in each direction. If the community square is larger, there tends to be less activity space in the home room area. Each group's space includes a larger room for active play and eating, another room for quiet play and sleeping, and its own toilet/washroom.

The central space is important to the program. Children are not strictly kept to their own room. Periodically they're allowed to wander out and play in this space, which has at various points has mattresses, little chairs, rubber foam material that fits together like a puzzle but can be sat on, games, etc. When we arrived, for example, two adults were sitting with infants in their arms and four other children were wandering around playing. At various points during the day children came out into this area, never really fully confined to their own room and with opportunity or chance to interact with others. And the interaction was constant, comfortable, and clearly being enjoyed. We noted that it was actually very difficult to figure out how many children were present because of the flexibility in movement from one part of the building to another. One group of about ten 2 to 3 year-olds were actually not in the building but off playing on a football field nearby in a special outing where they were also having a picnic lunch.

There is here (and throughout Denmark) strong conviction about sleeping in fresh air, perhaps a historical residue from the tuberculosis era. Children are placed in carriages and wheeled into the garden area (or - in some centers - in shed-like areas with protection but open windows). On the coldest days they are in sleeping bags in the cribs. During the summer the cribs are covered with netting. While left alone, the sleeping children are closely monitored. The carriages are used deliberately to distinguish outdoor sleeping from the indoor cribs. In a number of centers, children sleeping indoors began with an adult in their midst reading a story.

The normal routine in this facility is that the children arrive between 6:30 and 9:30 in the morning. Most of them arrive around 7 to 7:30. They have breakfast between 7:30 and 8:30 and by 9:00 there tends to be a somewhat more "structured" series of activities. The children when they first arrive play in the large open room. Group rooms are opened one at a time as they are needed, when enough of the children are present. Children have their lunch at 11:00, a nap between 12:00 and 1:00, and have outdoor play both in the morning and in the afternoon every day unless the weather is really very bad.

Parents are expected to call by 9:00 a.m. if they're not bringing their child. They're also expected to call if a child is ill. Children may be brought if they have head colds but not if they have temperature or have an upset stomach, for example. If a child gets sick during the day staff call the parent to take the child home. Parents are expected to pick up the children by 5 o'clock in the afternoon and most parents pick their children up before 4:00.

A group's main room typically has two large tables, a floor mat for sitting and playing, often a child-height mirror on one wall along one side of the mat. There is an enclosed area, equipped for playing house. Another area can be converted to a store. On top of that area, a play pen, about five feet above ground, allows an infant to see what is going on in the room. Shelves on one side of the room hold toys. Doors lead to the central room, the group's smaller room, the toilet/washroom and to the outdoors. There is eye-level glass in the door to the central room so that a small child may see what is going on. While no two group areas are quite the same, they all are light, bright, colorful, have ceiling mobiles and wall hangings - and are very attractive.

On each side of the building the changing areas in the toilet/ washroom are back to back and have a see-through window. The rooms have two toilets, a long low wash basin, changing tables, supply cubbies. In some a child's name and in others a symbol identifies personal clothing, pacifiers, toothbrushes, cups, washcloths - all strategically located in the different rooms. Each group's main room lists children by name, birthdate, parent's names. In the first group, when visited during the summer, the children ranged in age from 8 months to 36 months, five were boys and five girls, and three were Turkish immigrants.

The outdoor space is ample for the play period. A shed containing kiddie cars, trucks, wagons, ropes, and balls is beautifully painted and was in active use. The wall has murals developing the circus theme. There is one area for sand play, another paved for wagon riding, and a green area for other play. There is one wonderfully constructed hill with a slide down the front and a tunnel underneath so the children have a long crawl; we were told that they like this very much. In the winter it becomes a snow slide. The hill was relatively steep and when we asked what the little children did, the answer was that they work at learning how to climb up and eventually manage it. This is not in the protected area for the young children, but they periodically play there.

What was particularly impressive as the day went on and we saw children in the area was the fact that in effect they are pretty much on their own in playing with peers. There is an adult presence all the time but the adults are not leading them or playing with them. They are simply providing the opportunity for them to play and to interact with one another.

The marked off area for the very small children, a grass area, has four trees, birds singing, and a somewhat more protected environment for the very youngest children who needed protection. Some of the children played more actively and we were told that some of the twos and threes were at the outdoor football play place for free play. The staff member accompanying us said, "They will be home at 12 or 1 o'clock." They would be going every day this week but a different adult would be accompanying them each day.

The outdoor pattern characterized the indoor play as well, both in the individual group rooms and in the hallway. The adults were always holding an infant and interacting with a child or infant, yet they did not seem to be leading the others or guiding their play. The children were playing alone or mostly in interaction with one another and there tended to be conversation among them especially as one got to the older children. On the other hand, when we walked among the rooms while the young ones were eating they did all react to us.

As the meal was being prepared we visited the kitchen, a clean, well-equipped facility. In the infant/toddler facility, during the summer there are two cold meals each week and three hot meals. In the winter they have hot meals four days a week. In addition they have breakfast and a snack. On this particular day the snack would be a plate of fresh fruit from which they would make a selection and some bread which had been baked by the cook and looked very attractive. The meal for today, the lunch, would consist of a choice from platters containing eggs, a small amount of meat, bananas, raisins, and bread. The kitchen has one refrigerator for fruits and vegetables, another for milk and dairy dishes, as well as a freezer. We saw some other food on the counters and they explained that there had been a staff party on Saturday. We were told that it is a "good team" and they like one another and enjoy coming together in this way.

This facility has a staff of fifteen, including the director, plus the cook and a cleaning woman. Each group of ten children has three staff members assigned to it. In addition there is a substitute who fills in when somebody is absent. The director is not working with any of the groups (the practice in some places) but does fill in on an as-needed basis if a staff member is out unexpectedly or if there's a particular need. If necessary she can also take a child aside for special attention. About half of the fifteen staff members are professionally trained while the others are helpers.

While we were there lunch was prepared for the children. Lunch for each of the four groups is placed on a kind of tea cart and wheeled in to that particular group's room and served there. In one case one of the youngsters climbed up on the tea cart and got a free ride as lunch was being wheeled into his room. The atmosphere was everywhere relaxed.

In one of the rooms there were two 1-2 year-olds and a 7 month-old at a table being fed by the two staff members (one female professional and one male helper) and one male unemployed man carrying out his community work. In effect each very young child had an adult who was helping the child eat. The 1-2 year-olds were feeding themselves but the 7 month-old was being fed. The adults were eating their own lunch at the same time so that in effect children had a normal family-like meal with adults and themselves eating together.

In a second under-3 group, with the adults at their side helping, even the smallest children were feeding themselves. Two, under age 1, were being fed but two others, barely over a year old were picking up their food from their dish as the adult placed food there and were managing to feed themselves.

In the adjacent age-integrated facility one finds an under-3 group of ten in rooms much like those in the day nurseries. The under-3s remain apart here - one of several different philosophies of age integration, but they can be in the same program as siblings, and do not need to meet new children, new staff, or a new place at age 3, and they do learn from the older children as they interact. Yet, during much of the program day they remain in their own closed-off area and the older children come on invitation or request. This also is true during outdoor play. There are three full-time staff for these children, two trained *pedagogues* and one aide.

Child Care in Aarhus

Denmark's second largest city, in the western part of the country, yields illustrations of the shifting age-grouping theories and an emerging philosophy of age integration. All of these facilities, which can be mentioned only briefly to conserve space, are attractive, well-run and meet the test any foreign observer must put: would you be comfortable with your own infant or toddler, pre-school children, or grandchild in this facility all year long?

We begin with a day nursery in the middle of the city serving twenty-four children under age 3 in two groups in a beautifully renovated historical landmark, an 1850 building, once the home of a prosperous merchant. Why twenty-four children? Because the space was not adequate for the preferred thirty-six. They have as a consequence limited themselves to one- and two-year olds. The renovation was carried out by a planning team with the to-be director as a co-member, freed for the task, so the facility reflects sophistication about space arrangements and storage needs for this age group.

The facility opens at 6:30 a.m. each morning and closes at 5:00 p.m. four days a week and 4:30 p.m. on Fridays. The philosophy is to try to have as few rules as possible. Parents are not held to rigid arrival times with the children (although they are told about potential trips so children will be present on time). There is no rule as to whether the children do or do not have breakfast when they arrive, but they must arrive by 8:00 if they want breakfast. In general the philosophy is parental choice in how they use the facility and as little structure as possible. Staff talk together about what they will be doing day by day. They respond to the needs of children and the grown-ups who are present. They try to work on the issues that arise out of need/desire. If things are not working, they will discuss the fact they are not functioning well, not that they are not meeting certain goals. The response, as indicated, is in relation to need, not in relation to schedule or plan. Most children are present by 9:30 a.m. and stay to 4:00 p.m. or 5:00 p.m. A few arrive as early as 7:30 a.m., most come in the period 8:00 to 9:00.

There are nine staff members, one of whom is full-time and all of the rest are "part-time". Of the part-time workers all except one work between thirty and thirty-seven hours! The one who works less than thirty hours works twenty-seven hours a week. Those who work less than thirty-seven hours a week tend to prefer fewer hours. Occasionally when the municipality is cutting back on expenses, there may be some need to curtail staff hours. When that happens, staff may decide to work one or two hours a week less. If staff work thirty hours a week or more, they are entitled to full benefits. If they work less than thirty hours a week they are formally defined as part-time and have a lower pension entitlement and lower unemployment insurance benefits.

Two staff members, one for each of the two groups, arrive at 6:30 in the morning. A third arrives between 8:00 and 8:30; four days a week, by 9:30 in the morning, there are four staff. One day a week there are four staff only by 10:30. The first staff member to depart leaves at noontime. In effect, each group has twelve children and one *pedagogue* and two helpers.

The relaxed philosophy of following the child's leads is exemplified in indoor and outdoor staff-child reactions, responses to parental pressure about child naps or toilet training, and mode of discussion. Great emphasis is placed on communication with parents about what has occurred through the day, especially through a "diary". Children have open mobility in the facility - and may change groups or sub-groups at will.

There is a sparsity of formal toys but many useable "things" and materials.

The following mid-morning outdoor scene is characteristic:

Most of the children were outside, a few wandering in to play inside, and it was a very active period involving the entire staff. One might have expected the only available outdoor space of cobblestones, sheds, and a constructed yard - the original building - to be inhibiting but it was not so. (Of course there are trips to green space and plans to get some next door.) The equipment is carefully limited to avoid falls on the cobblestones.

Staff were engaged with the children in much of the play and although children were quite free to wander off and play by themselves and interact with one another, a good number of them were interacting with staff. A group of five girls were sitting on some blanket-type material and playing house. They had cups and saucers and various other things and seemed to be engaged in animated discussion. They also were caring for one little boy, the brother of one of the girls. One of the male staff members was sitting in what looked like a dog house, but was obviously meant to be a doll house with two children, and they were having a very enjoyable time. The director commented that the children love to go in there and hear stories. A few of the children were riding on carts and trucks. A few were playing with soccer balls and other equipment. There were a number playing with sand as well. In a shed-like area, the converted toilet house, there were various other toys and strollers so the children could be taken for a walk. On a wooden table outdoors was the diary on which some of the staff were writing about what the children were doing so the parents could read it later. Moreover, some children were missing; they had as a group gone to visit one friend whose mother had a day off and had invited them there, and (as indicated) some had gone shopping with a leader in town.

Just outside of Aarhus is a suburban child care facility designed for eighty children in the 0-14 age range but, when visited, the after-schoolers went up to age 10. Theoretically, the youngest child can be six months old, and one was to be admitted next fall (this being mid-summer). Much doubt is expressed about the ability to attract children over age 10, given their other interests and there are those who see the 0-6 groupings as most viable (see below).

Here the director and staff have taken a facility designed for four groupings and organized three groups instead. The space for the fourth group has been converted to an atelier, an afternoon studio workshop for three children age 3, ten in the 3-6 range, and ten from 6-10 who come after primary school (which begins with a short day and gradually expands its hours). The older children tend to paint, work with leather and do other things appropriate to their ages, and the preschoolers watch them in the afternoon.

Here, too, the under 3s have a long day, eating breakfast if they arrive before 8:00 a.m. and being served a hot lunch and an afternoon snack. The pre-schoolers have breakfast and the snack but bring lunch. The older groups have lunch at school.

The philosophy of no formal curriculum is present here, too. Having begun with the usual groupings (0-3, 3-6, 7-10), staff moved towards age-integrated programming as meeting children's needs. Children are not told what to do. They are free to explore and learn, and staff facilitate. There is no need to move to a new facility and to meet new children and staff at age 3 or 6. (They of course go to primary school at 6 or 7 but this remains their after-school program). The staff see value in a family-like environment in which, in fact, several children from a family may be found. The argument on the negative side is that it is not possible to stimulate children adequately without focusing on one age group at a time. The response is that the best stimulation comes not from a formally prepared, age-related, activity, but derives instead from children stimulating children. Older children are seen as gaining from learning to talk to a younger child, to be nurturing, to care, to teach. Children in groups take the lead of a "competent" child.

Here they do for some purposes facilitate natural age-grouping for some activities, having set aside space which is not part of group rooms for a "hair salon", a climbing room, carpentry, a tumbling room, a special protected sleeping room with fresh air.

One sees in this center the youngest children in warm relationships with pedagogues. In one room an 8, a 5, and a 1 year old, with a male staff member, were talking, playing with a doll, playing house - while the others in the group were outside.

One of the notable characteristics was the ease with which the children moved from inside to outside and back again, sometimes with other children, and sometimes alone, sometimes with a staff member, all of it quite casual, quite fluid and yet never with a sense of chaos. There was exuberance, vitality, physical activity, talking, child to child interaction as well as child and adult interaction. This means first of all that although children are technically in a "group", they certainly do not remain with the group in the course of the day while they are playing. In addition since the children move around with such fluidity, it seems that they are not necessarily under the supervision of the staff person from their own group at all times, and indeed may not be directly supervised by any staff at all times. There is also an assumption that the children will take care of one another, and that if an older child is present and there is a problem with a younger child, that will either be taken care of or reported to a staff member. On the other hand, staff do monitor the very youngest children much more carefully. Throughout, it is more a matter of the staff responding to the play initiated by the children, helping them or joining in, rather than giving program leadership - this being the program philosophy.

What is most impressive is the very extensive outside play area. Off to one side there is a small area that includes a small sandbox and swings that can be closed off for the very smallest, but that in fact is also used by somewhat older children as well except when the littlest ones are sleeping. In addition on two sides of the facility, there are very large sandboxes as well. There are two sets of swings, a climbing facility, a slide, a small house, a shed that can be used by some of the older children as a clubhouse and can be locked up. There is a large open field for the animals, and there is a tent that was purchased recently and that some of the children were using to play Indians and Cowboys. There were near the facility the usual picnic tables and benches.

There is also a tiny "wooded area" that had not belonged to them initially, but which they had taken over since nobody had objected. It is left very rough and the children used it as a forest; and we were told by the director, quite proudly, that the children loved the freedom of this area.

In several of the areas children seemed to be very much on their own, very independent and not particularly supervised. Nonetheless, in the course of two hours nobody cried, nobody fell, there were no fights, there is no screaming. It is a remarkably unstructured, loose, child-determined milieu, in a situation in which the staff seem to have a good deal of awareness of what is going on and a real sense of what they and the children are doing. Among other things going on, two of the children were washing the outside of one of the windows, mimicking a window-washing process, all in honor of the visitors.

Another facility in a suburban community outside of Aarhus is converting from its under-3 program to an age-integrated center serving children to age 6. There are forty children in the center at the moment in groups of twelve, thirteen, and fifteen but the full capacity will be three groups of fifteen. The full staffing pattern is two *pedagogues* and two assistants per group. Hours are staggered by attendance flow; not all of the present thirteen staff members are full time.

Here, too, there is the shared entry room, and each group has its larger activity room, a smaller quiet room, a washroom/ toilet/ changing room. There is a good deal of activity in the center room, which is criss-crossed to enter a given group's space. There is climbing equipment, a tunnel, steps with a mat below, flat pillows and mats that can be arranged in patterns, a stereo which children can use. The bigger children eat their box lunches around tables in this center space; the younger ones have the hot meal in the group room. While the group settings are comparable, equipment, decor, arrangements, special charts and lists, and group member identifications vary - the whole reflecting the *pedagogue's* way of working.

To illustrate one possibility:

In group one, the big room for the group as well as the second room are set up like a four-room apartment. There is a living room area with a couch and a rug, a bedroom that has an adult-sized mattress and a child-sized table and chairs as well as doll cribs. There is a mirror on the wall, and there is a fish tank. There is a dining room area that has two adult-sized tables. There is a kitchen area as well with a small stove, a place for pots and pans and dishes and so forth. Next to the adult-sized bed are a series of compartments in which about six mattresses are kept. These can be put on the floor for sleeping for the older children, while the younger ones are out in the sleeping room in carriages. The carriages, again, are in a cement room which is glass enclosed but the door can be opened for outdoor effect. There is a clothing drying place as well.

This pattern is duplicated in the other group areas, but not in this complete form. One group does not have a sleeping room, it having been converted for use of clay and sand, so the sleeping room is shared with one of the other groups.

While we were in group one's rooms, two little girls who were playing there were coming in and out of the room and we saw them repeatedly in the context of the rest of our visit. These little girls who were a little under 3 years of age, beautifully dressed, one in a blue-jean overall, and the other in a pink and white little dress, were "best friends" and acting as "little mothers". We saw them first taking their dolls and putting the babies to bed in the doll cribs in the "bedroom" of the "apartment". All of the other children in the group were outside, but these little girls were doing their thing.

The second room for group #3 has a couch, a table with high chairs, and a large playpen. There was a 8 month old in the arms of a staff member who was sitting on the floor. There was also a carriage room and one of the carriages was outside with a baby who was sleeping there. The 8 month old, a baby girl, was very responsive, smiling at us and at the staff. A few minutes later a very pretty 4 year old little girl came to play with the baby and we were told that this is the baby's sister, who had been in the program since she was under a year. The 8 month old had been coming to the center since she was 3 months old, a unique situation considered to be relatively unusual here. Both these little girls are the daughters of a lawyer, who had found it necessary to go back to work earlier than her six-month leave would have required of her.

There was also a rather quiet little boy standing there holding a stuffed animal, who came over to the director. She explained to us that he had just returned from the dentist, and although all is well, nonetheless this is not his usual demeanor. Within a few minutes he became much more alive and a much more active participant.

There was a lot of activity, much running around, and three adults sitting in the middle of the room, one of them with a very small child. One would need to describe this as a warm comfortable environment for children in which they all seemed engaged and interacted with one another and with the adults. As we were walking along in the room, a small child, between 2 and 3, came over and grabbed the director calling to her "Lotte", "Lotte". She responded in the same sing-song rhythm "Katrin", "Katrin". There is affection on both sides.

Each of the "home rooms" has large, high windows to the outside, so that one feels that one is always in the good outdoor space, to be described subsequently. It should also be noted that there were here a larger number of men than usual. One of the *pedagogues* and four of the assistants are male.

Although each of the groups is age-integrated, children sometimes play across groups with children of the same age. The total facility is small enough for such connections. So one sees both age mixes and patterning by own age at different spots.

There is a quiet outdoor side protected for sleeping for the youngest children. Another area has swings, climbing facilities, a tent, and two male staff members were playing ball with one of the boys. In another part of the outside space, there is a shed, and the same two little girls we had seen earlier with the dolls were now playing with other toys, but still playing with one another. In a third area, three staff members were sitting with four children under 1 1/2 years of age in a group on a mat and playing with a sandbox and some toys. There were also two or three boys on bicycles, on other kinds of toy cars, and some boys climbing on a special piece of equipment that is shaped like a ship.

In one large sandbox area and the adjacent playing area, there were sixteen children playing, sometimes in smaller groups, and sometimes in larger groups, with two or three staff members sitting nearby, but not actively involved. Later on we saw one child fall and cry for about two minutes. A staff member picked her up and that was the end of the crying - the only crying we had encountered in Danish child care.

The quality of the outdoor equipment is very imaginative. There is one wooden ship, and there is one bridge which we were told were produced some years ago by a workshop in the community for unemployed youth who take on carpentry tasks for centers and similar places. This ship and bridge had been prepared on order.

To sum up, one found here wonderful outdoor space, imaginative materials, a warm environment in which children were clearly comfortable, a good deal of exchanged affection. And a relatively high rate of adults present to children. The children were interacting with one another, animated, talking, and imaginative in their play. It may have seemed a bit more hectic than many of the centers elsewhere, but is hardly disorganized, even though not tightly programmed by the adults.

2. Family Day Care in Two Communities

Family day care, as we have seen, is the most commonly used child care mode for the under-3s in Denmark. It began as a municipally-operated program to meet a transition need but currently is popular enough to hold its own, and there are some child development experts who stress its special merits. The informal, unregulated, black-market family day care remains an unsatisfactory expedient, used while the formal supply grows. Even Denmark's high coverage rate for the under-3s is said to be behind demand.

Family day care in the municipality of Hvidovre is managed by a team of eight administrators who have been day care center *pedagogues*. They visit and give leadership to the childminders (family day care mothers). They are currently responsible for 112 child minders with 360 children, as well as for screening new applicants. The family day care children are all under-3s here, it being felt that family day care is not an adequate socialization context for older children. This community also has 582 children age 6 months to 3 years in fifteen nurseries and a larger group of older children in 87 centers. Another 308 children under age 3 are in age-integrated institutions and kindergartens. Staff are surprised to hear that family day care is the dominant under-3 mode nationally.

Parents who want municipal child care services fill out an application in the local social service office (which also covers health visiting, child welfare, recreation and other services). Applicants are provided with a pamphlet that explains family day care and also lists addresses, sizes, age-spread, and hours for each center. They are expected to specify a preference as between center care and family day care and six out of ten list the former. However, since there are waiting lists, if there is a family day care opening a parent who is waiting for a center may nonetheless be called and may accept. Once a particular home (or center) has been accepted, a shift within the municipal system will not be possible for six months.

Whether for family day care or center care, the parent who is reached on the list visits and talks with the potential caretaker. After three months a form is sent to ask the parent's reactions and whether a change is requested.

The officially assigned workload ratio is four children to one family day care mother. The staff prefer three, and that is the prevalent mode. However, twenty family day care mothers do have four children. Own children under age 5 enter into the count but are not paid for. Even the pattern of three children means that, covering for someone else at holiday time or for a family day care mother's illness, could raise the count to five.

There are both older women and young women among these care givers. The younger women may have the their own child and care for two others. Many have previously worked in stores, banks, or offices. Among them are supporters of the traditional family who do not want out-of-home work.

An applicant for the family day care assignment responds to word of mouth publicity or an advertisement and phones the municipality. A brochure is sent: "Do You Want To Be A Day Mother?" Applicants submit name, address, and phone number and are asked to include a brief note about themselves (a planned revision will ask for more information). Each applicant is visited by a two-person team, the director of the family day care unit or her deputy and the administrator (a *pedagogue*) covering that geographic area. They look at the home, observe the woman with her children, discuss the children, and try to make some judgement as to capacity to offer a child a warm relationship (in a clean, safe, stimulating environment), Police and social service records are cleared to identify serious personal problems (but need for income or a social assistance record is not disqualifying). A single mother is not automatically disqualified, but staff see it as an obstacle; it is exhausting for women to be with children all the time and not to have anybody else. Some women have been accepted who have not themselves had children. There is a 40 percent rejection rate of applicants.

Once a child has been placed, *pedagogues* make a visit at least twice a month and these visits are relatively long. They play with children on these visits, sing to them, talk with the family day care mother about the child and its care, and eat with them. Later, there will be opportunity in the "playrooms" (see below) to see a family day care mother in interaction with her charges, with other children, with other mothers.

The back-up arrangements in Hvidovre underscore the differences between professionally led municipal day care and the informal ad hoc arrangements of most American communities. Each family day care mother is teamed up with two alternates, a primary one and a secondary one, to give coverage for illness, holidays, and emergencies. These alternates meet one another and the children get to know them, because they are scheduled to come to the "playroom" at the same time. It means the child can feel safe with the other adults.

The playrooms are modeled on day care centers but are specifically set aside for the use of family day care mothers. In this community there are three such facilities: one in a detached single-occupancy house, one in a converted center, and a third in an apartment house. In two of the districts the family day care mothers visit these "playrooms" bi-weekly, while in the newest one, the apartment unit, the care givers will be able to visit once each week. In effect these are facilities used only by the family day care mothers and have no special staff assigned to them, although the district *pedagogue* does visit periodically, probably about once every couple of weeks or once a month.

The family day care mothers' visits to these playrooms are scheduled in such a way that they and the children in their care, their first backup care giver and her children, and the second backup care giver and her children all visit the playroom the same day each week. They are also scheduled together to take the same trips, the same excursions, and so forth, the objective being that the child and the parents both get to know the backup care givers and the children in their care as well.

There is an "open house" for the children's parents to come and visit in the playrooms two times a year for each of the groups. In addition some of the parents organize special activities using these playrooms.

The playrooms are open and in use all day, five days a week, but even on the day that care givers are scheduled to use them they may not use them the full day.

Family day care homes follow the same schedule as the day care centers. That is that they are open to receive children from 6:30 a.m. until 5:00 p.m., forty-eight hours per week. The difference between these homes and the day care centers is that there is some flexibility in the scheduling so that one provider might open at 6:30 in the morning and close at 3:30 or 4:00, and another might open at 7:30 or 8:00 and remain open until 6:00. There is no special evening family day care or weekend care, but there can be arrangements for emergency situations. Thus, for example, if a women is giving birth to a second child and the father is away, the family day care mother will keep the child she's been caring for in her home for a few days.

In contrast to practice in some other countries (e.g., Finland), in this community family day care homes are always located in the care giver's home. There are no group family day care programs, either, or, in the French sense, "mini-crèches". If the family day care mother gets sick she must call the chief of the program or the deputy. This of course tends to be very early in the morning and the call is made to the home. The chief or the deputy then calls each child's mother and calls the substitute, and then the children are brought to the substitute. This means there can be a lot of staff activity very early in the morning at home.

The municipality pays care givers between U.S. $563 - 596 per month for each child; one-third of this is tax-free. The parents in turn pay $173 for each child. This fee includes breakfast, lunch, and a snack. Parents provide the diapers. (The parent's fee per child 0-3 for day nursery care is a bit higher and the kindergarten fee is lower.)

If families have more than one child in care the fee is reduced by 35 percent for each child. If the child is home on a holiday or home for vacation the parent does not have to pay the fee for child care although the child care provider continues to be paid by the municipality.

From the municipality's point of view center care (capital costs aside) costs about 20 percent more than family day care even though the family day care staffing ratio is roughly 1:3 and in center care it is 1:4.2 - because center care staff is more specialized and more expensive. Yet the differences are not large, until the investment in building and sites is considered. This child care mode recruits successfully, but not actively when funds are short, so there are the waiting lists. Turnover is very low by U.S. standards.

Children with handicaps may be placed in family day care and the family day care mother is paid as though one of these children is two. Racial, ethnic, or religious discrimination is forbidden and a reason for rejection of a woman who applies for the post. On the other hand they are only beginning to consider foreign women as potential family day care mothers since facility with the language is considered essential.

Discussion with experienced staff yields the explanation that some parents prefer family day care as closer to their own home situation. They believe it to be a smaller and more intimate setting in which their children will receive individualized treatment. Despite these parental views, the family day care administrative leaders themselves see a strong case for center care over the much-improved family day care. The center offers greater opportunities for stimulation, there is better physical equipment, superior results can be observed with regard to social development and independence. Perhaps family day care is superior with some particular family day care women, but on average center staff have better qualifications. (The research is discussed below.)

The playrooms for family day care mothers and children are central to the administrative and professional concepts which guide the Danish system. The pattern is varied among communities and Hvidovre is outstanding. In general, the Danish system is unmatched and an outgrowth of the acceptance of family day care as an attractive mode. The most common variation in other countries and the United States is the "drop in" child care center, whether family day care mothers and their charges may come and go at will, as may mothers and grandmothers with their charges. In these latter instances the facility is part of the family support network, not an essential ingredient in a reliable, professionally-guided family day care delivery system.

These playrooms are not all the same; form and concept are evolving. One is located in a converted small house and its modest surrounding garden. The second is a small, converted day nursery. The third is a small, free-standing building, close enough to a local, small playground to use it. Each is physically an alternative to a family day care home, but clearly modeled on the day nurseries in the area. At the set times, about six family day care mothers and their charges come together every two weeks for as much of the day as they like. (Since there is no staff, arrangements are made about keys, etc. There is cleaning between groups.)

Groups that are nearby make it a full-day excursion, bring their own food, and the children have a nap. If the distance requires train or taxi transportation it is for a shorter day. Nonetheless there is time for the children to interact with one another and with other potential caretaker adults. Moreover, this also is a place for the family day care mothers to have exchange and conversation. The responsible administrative person may drop in - since she is constantly arranging the patterns for emergency and holiday coverage. The director or her deputy may come by to see about supplies or equipment.

One facility visited, the converted house, had six caregivers and nineteen children present. The daughter of one family day care mother, home on a vacation day, had come along and was enjoying playing with the little children. One entered via a garden which, on the right, has a shed with wooden cribs protected from the elements, where the children could actually be kept out-of-doors "in bed". These were cast-off cribs from centers that had extra equipment; indeed, the entire house is equipped with material that was discarded by centers. In back of the rather adequate garden for this type of group there are several play houses that were built by volunteers. There are a lot of trees, good grass, and a pleasant area. Children were playing outside on grass and in sand piles and a large number of others were inside. Everybody was active, enthusiastic and having a good time. The carriages in which they had come were protected from the elements by another shed, and they could sleep in them. The very little children were charming -- playing, walking, riding little carts and wagons. They talked back and forth and shared the experience. The family day care mothers were close at hand. The children had just had lunch and would soon be having their naps.

As one enters the one-story house of light brick, it is clear that this house was not physically converted to be a center. Nonetheless, the philosophy of the center dictated the arrangement of the rooms. Thus, there is one with tables, mats, shelves, toys, etc., like the large room in a center, but here a small room. It is large enough because much of the time is spent by children in the garden. We were told that in bad weather the house would be quite crowded and there would be more crying among the children. There is a small kitchen which is used for snacks, for heating baby food, occasionally for holiday cooking and when there is a party. And there is, as in the centers, a changing room. Here, however, there are no child-sized toilets or sinks. They took the house as it was.

One idea discussed among staff is the possibility of having a staff member assigned full time to each playroom. This would simplify coverage for family day care mothers who are ill or are on vacation - and would ensure holiday coverage as well. Staff could also enrich the activities when the family day care mothers come with the children, might take care of equipment and supply needs, and so forth.

In an Aarhus suburb (to broaden the picture), one of seven municipal social service offices is responsible for 160 family day care homes with 520 children in the 0 to 6 age range. For this purpose a supervisory staff of ten *pedagogues* and one secretary can ensure one (unannounced) visit each month and applicant screening. The supervising *pedagogues* monitor each child's welfare and development, spot problems, and support the family day care mother with practical things: prams, beds, diapers, toys. They give much attention to the caretaker: child match.

This suburban area, centrally located, is a new town (1968) with attractive high rise buildings and shopping centers. At the core it is 70 percent foreign born, largely Turkish. The area houses 15,000. Thus far, despite efforts, not many foreign women have been recruited for this work. Among the Danes it is respectable work and carries a good salary. Not so among the Turkish women who have many children and do not accord status to work in family day care. New experimental efforts are planned.

The screening and interview routine here is similar to what is described for Hvidovre, with great stress on personality suitability. Since in Denmark everybody has completed eight years of schooling, there is no issue of illiteracy, but good speech is valued. A successful applicant is placed in an existing family day care home for two weeks of training and there is an additional two weeks within the first year. They are taught basics of child minding, some psychology, something about food, something about setting up the apartment for children, the importance of the outdoors. The two-week course is given by a *pedagogue*, a pediatrics nurse, and a psychologist. Once the family day care mother has settled into the work, she may have a one-week training period each year on special topics.

After the family day care mother is accepted, a beginning date is set. They try to place quite a number of children at the beginning of August, the end of the vacation period. Since new family day care mothers are to have at least three children, these are spaced in over a month and a half. Within thirteen weeks they build up to capacity and that is the trial period.

During the thirteen weeks when she is on probation a family day care mother can be fired with one week's notice. After that she has the right to three months notice.

In assigning children they try to mix the ages if possible. The goal is four children, the average is 3.7, not counting own children within that age range. What they like to do is to give the mother two infants below age 2. Parents like their child to have a playmate of similar age. In deciding whether the mother gets three or four children, they take into consideration how old her own child is. Thus if she has an infant then she will not be given more than three children.

Family day care mothers in this area are paid $564 per month per child. Thus, with three children in care, they are paid more than 60 percent of an average female wage. One-third of this is tax free because it is defined as covering expenses and depreciation. The income is about equal to the highest level of an unemployment insurance benefit. It has the advantage of not involving any of the usual job costs such as transportation and so forth. Family day care mothers are required to work a forty-eight hour week. However they have six days of paid personal leave per year, five weeks of paid vacation, receive full pay when they are sick, up to 120 days a year. All of these generous benefits and relatively generous pay ensures high quality in family day care mother groups, according to staff. The family day care groups are stable after the sorting out of the young women who see it as a transitional arrangement for eighteen months.

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Aarhus does not have the family day care playrooms seen in the Copenhagen environs. On the other hand they do have a group play space where groups of family day care mothers can come together. The pattern here is a bit different. They create groups of ten or twelve family day care mothers and either weekly or sometimes as often as two or three times a week (but sometimes only on alternate weeks), they meet in these centers for talk and exchange of experience and for the children to play together. They do not have the separate play center facilities we saw in Copenhagen for these gatherings. Instead they used church space, schools, playgrounds, other buildings. Children have opportunity for singing, dancing, painting. There is one substitute family day care mother for each group of ten or twelve mothers, however, a way of meeting emergencies. But the mothers also substitute for one another if there is greater need. The substitute is somebody who is given a full salary as though caring for four children, but has no children assigned. They tend to look for an experienced outgoing type of person, and this person becomes a valuable resource. But, again, family day care mothers get to know one another and children placed with different women get to know one another, so some interchange is possible in case of illness or other emergencies. There are fourteen substitutes in this system.

Once a child is with a family day care mother, the tendency will be to remain until age 3 or 4, or sometimes even to 6. There are exceptions; mention was made of a 14 year old retarded child still in care. However, if the child is over 7 an annual application for extension must be made and the situation must be reviewed.

3. Home Health Visiting

Given the major British shift to more targeting and the tendency elsewhere for such targeting (Finland, Italy, Sweden), all on the foundation of a public maternal and child health service, Denmark is the major exemplar in Europe of the on-going role of a health visiting program with multiple visits to all families during the first year especially. As will be noted, while the public health nurse is the "line" practitioner, the program has important social as well as health goals. And despite municipal variations, there is a major core of shared policy and practice - and widespread public appreciation of a high-quality universal service.

We present the program in Helsingør, north of Copenhagen, on the coast, as an exemplar. We went into the field with two public health nurses working in Green Garden, one of the four local areas into which the city of 60,000 is divided. The whole city fields nineteen public health nurses, twelve of them full time, covering 685 new births a year, or about forty per nurse.

Servicecenter Gronnehave, in Helsingør, Denmark

This was a visit to acquaint ourselves with the work of public health nurses with young children and their families. The city of Helsingør, on the coast, north of Copenhagen, is the locale.

We began by meeting with the two public health nurses specializing in work with children, SV and HSS. After

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introductory discussion the two visitors went into the field, each with a nurse, each to visit two families on the "caseload".

In the preliminary discussion the nurses explained that the law says that an offer of service shall be made to the families of all newborns. In effect, it is not a mandate, but an offer, but neither of the two has ever experienced a situation of refusal. This is a universal service. Families might reject a particular nurse, while accepting the service, but that too is rare although it is known to occur.

The city of Helsingør is divided into four local areas and this is one of them, known as Green Garden. Part of another local area staff actually uses this office as sort of an overflow. This is not the biggest building; there is another one for the other areas. Helsingør is a city of 60,000 and there are nineteen public health nurses, twelve of them full-time, covering this load. It means about forty new births a year per nurse, 685 in all. And in addition they have some responsibilities, as indicated, with school children. Each is responsible for one school of approximately 600 children. In effect, they get to know all of the families as children are born and then continue with the children as they go forward in school. The family gets to know them. Occasionally the nurses are assigned cases outside of their particular area as equitable coverage is assured. This particular area is a relatively high-density one, but the territory includes many low-density areas. The nurse relates to the child for the first six years of life. They have certain other public health responsibilities, one new one involving consultation to the commune on AIDS. They also cooperate with child care facilities in their areas, visiting about every three months to answer questions with which they can help day nursery staff. (The focus, generally, is on the under-3.)

In the instance of a first birth in a family there are ten desired visits from the time of the mother's pregnancy until the child is 2 1/2. We mean "desired" here in the sense that ten visits are offered. They don't always take place, as suggested subsequently. At the time of the first visit, when the mother is nearing the end of her pregnancy, they explain the child visiting service and offer it. The first visit with the child will be after the mother's return home from the hospital. At the time of each visit they ask the mother when she wants to see them again. In general the response is to want them to come more often than they can manage, rather than to discourage visiting. When the mother wants them more often than they feel they can or should go they would say, "I'm coming an extra time", but they only do it if there is a real reason and they tell the reason why they are willing to come again.

A bit of a problem is arising about the pregnancy visit. It had depended on a note from the midwife center, telling them when the time was to visit, about a month before childbirth. There is obviously some competition between the midwives and the nurses and the midwives seem to want to discontinue the notices, indicating that it is something of a burden. However, there are notices posted in the hospital so that the parents can call the nurses. What is more, the hospital provides a notification of the actual birth so that the nurses can plan their first visit. Another source of information is the physician providing prenatal care. In addition, there is good cooperation with the social workers at the hospital and social workers working with families for any other reason. Nonetheless the nurses are concerned and recognize that this is an inter-professional tension. There is some worry that the parents with problems and the less secure parents are the ones who will not be calling on them. (We did not find this problem on a visit to nurses in another community.)

Part of the reason for wanting the pregnancy visit is the fact that they then become acquainted with the mother and get a sense of the anxieties, the concerns, etc. Then a contact after the baby's birth gives some sense of how the adjustment and adaptation is taking place. If, for example, they have discussed the mother's expectations about the birth of the child and how it will affect the family they will be able to continue after the child is born pursuing that line of help. They get a sense of the family's life and what the arrival of the child does, what family supports are available, etc.

The record kept from the time of the first visit, which was shown us, is really quite factual if all goes normally. The mother, in addition, is given a baby book for a record of the visits, in which the nurse makes an entry every time in the home, as indicated subsequently. The family also brings that baby book on visits to the doctors. When the child is 1 year old the nurses complete another form with the parents and that then becomes the record that the nurse keeps on file in the office as long as the child is in the system (for ten years). It is transferred if the child moves.

The following is the usual pattern: The child is born, the nurse has been informed, and the nurse visits the home as soon as possible, usually within the week. She examines the child at home, examines the mother, and then returns in two weeks. If there are problems with the child, and the child must remain in the hospital, the nurse will get a call and will see both mother and child in the hospital. The next visit at the home, here, too, will be in two weeks. And then another three or four weeks later.

The typical pattern for visiting a family with a first child, apart from the pregnancy visit is as follows: first week, two weeks later, three or four weeks later, three months, five months, eight months, age 1 year, age 1 1/2 years (these two now being combined), age 2 1/2, the end of this visiting process. This means ten visits in all. Parallel to this the doctor is seeing the child both for inoculations and for checkups. The checkup visits are at 5 weeks, 9 weeks, 5 months, 6 months, 2 years, 3 years, 4 years and 5 years. The vaccination visits are at the time of the 5-week visit, the time of the 9-week visit, at 5 months, at 6 months, and at 10 months. Both nurse and doctor will be seeing the family more often as problems or needs arise.

In the case of a family with several children there will probably be six visits between birth and 1 year and that will be it. On the other hand, where there are social problems, uncertain young parents, poor development, the nurses may go often, make concentrated efforts to help, and even continue to the age of 6. It is not that the single mother per se automatically gets more visits or is regarded as a problem, however; the nurses really look at the exact situation, how the child is developing, and the mother's situation as well. In general, this is truly a universal service. It looks not at the category of family or of mother or of child, but at the way in which they are functioning or interrelating. As needed the nurse or doctor can make referrals to the social worker and themselves move into a more secondary role if it seems appropriate. They cooperate with other professionals who are visiting with the family if the family needs require it.

In their discussion the nurses mentioned "young parents". When we asked about this, we were told that they then mean parents of 16 or 17. But they also have some older parents here, a rather surprising number of 40 year old women having babies, something which did not occur in the past.

They stressed, and others have stressed to us, that these nurses are welcomed into the home, more so than the social workers who are seen as sources of authority and possibly acting to control or even to place the child.

The typical visits are an hour or an hour and a half in length. The nurses do what they have to do, try not to overstay, but it takes them that long (as seen subsequently). They're interested in the baby's development, family problems, family/child contacts, child's appearance, any problems they see. If indicated they can make appropriate referrals. Part of the reason that the referrals and the coordination are easy, it should be noted, is that the offices of these public health nurses are shared with the offices of the social workers and they are part of one department, the Social Service Department of the commune. Thus, in the building in which this interview was taking place, there was a common entrance, an information point, and a waiting room, attractive and comfortable. Down the corridor to the left were only offices of social workers. In the other two corridors there were some offices of nurses but also some of social workers.

Other referrals are to the family doctor, who in turn can make a referral to a specialized pediatrician, or a psychologist. The nurse can herself refer to the doctor and the psychologist as she can to an ear and eye specialist. Other specialists require referral by the family doctor, except for a speech therapist who is available to nurses as well.

As complex situations arise and there is need for some guidance, the professional, e.g., the nurse or the social worker, can bring a case to a conference. The conferences regularly include somebody from the family center, a head nurse, psychiatrist, and a social worker and they will staff cases brought in by any member of a team working with a family. Sometimes *pedagogues* are included. The usual way to make a referral is to discuss it with the family and make it with their knowledge and acceptance, but it can be done otherwise if it does not seem like a matter appropriate to discuss with the family, but in that case they do not give the family's name in the conference.

These nurses feel that they have a very good situation in terms of inter-professional relationships and staff ratios. They can do more than some towns. And they're talking more and more about somehow building up preventive work on a larger scale, particularly with attention to young mothers and immigrants. In fact they regard their team as quite powerful and effective in combating threatened budget cuts, for example.

Certain families are likely to get more attention from them or to be defined as high priorities. These include young parents, parents with alcohol problems, parents with a physically or mentally or emotionally handicapped child, parents with a child experiencing developmental lags, immigrant parents. Of this group, the ones that they define as being the hardest to reach are the young parents and the immigrant parents; and these are the families for whom they are exploring alternative strategies for access. Part of the reason that they think they will be able to reach them is that in this district they have an unusually high ratio of nurses to newborns.

Field Visits with Home Health Visitor, SV

SV is a rather large blonde woman who was wearing a white blouse and printed culottes. She tended to be rather sloppy in her manner and appearance, or at least was certainly very informal. She also wore sandals which she kicked off her feet during two of the visits at which she was observed. The point about all this is these were very informally dressed nurses and there was nothing formidable about their appearance as they entered a house.

The first visit was to a family close to the "center" of the city, living in a small brick house. It had a moderate sized garden with one tree and some grass and the family was sitting on a kind of back patio at the time that we arrived with another couple and their child visiting. The friends were about to go off on vacation. The husband was also present, so both parents were present with the baby. This was the first time that this had occurred and the nurse thought that perhaps the father was there because they had been told about the observer's visit and had been asked to give permission.

This case was selected because the child was 10 weeks old, cried a good deal, and the tense mother called the nurse very often and asked for as many visits as possible. The nurse has been going frequently. The mother seems insecure and asks all kinds of questions about the baby's appearance, eating, crying, and about how she deals with the baby and whether she is causing trouble. En route, when asked about the parents, the nurse told us that the mother did some kind of therapy (we later learned "occupational therapy" and perhaps this was a language problem) but she didn't know what the father did. On arrival, when the observer asked the father about his activity -- since he was at home and apparently able stay home -- it developed that he was a psychiatric nurse (it wasn't clear at what level of training). We were also told in advance that the father has two older children in a prior marriage and thus has some experience, as a parent, but this is a first baby for the mother.

This nurse (as do others) has two phone-in periods, one on Monday and one on Thursday, but parents also can call anytime between 8:00 and 4:00 and leave a message with the secretary so that the nurse will call back when she has time. En route she explained to the observer what she was going to try to do on the visit: It was clear enough to her that every time the baby cried the mother was breast-feeding it, as if the cry always was a signal of hunger. She wants to make it clear to the mother that crying need not be a signal of hunger. Maybe the baby wants her to walk with it or to talk. This is a common misconception. Perhaps the excessive breast-feeding makes the baby uncomfortable and then there is crying. The mother somehow has not learned how to be sensitive to what the baby is communicating. The nurse's intent, therefore, was to model a different type of approach: to show how the mother could handle the baby, do other things, see other needs on the part of the baby in the hope that the mother would understand. She has found it pointless simply to tell the mother such things because they are not heard and the same questions come again and again.

The home, in which we sat after the friends had left, was disordered and dirty. There was a living room, a kitchen, a bedroom area, and a kind of alcove area in addition to the bathroom. The child was kind of weepy, being held by the mother, but the father took over a good deal of the time during the visit. He held the baby very well and seemed to know how to do it. The nurse sat down with the mother at the table and the father was walking around with the baby, holding it, and occasionally joining in the conversation. When a comment was made by the observer about how skilled the father seemed with the child he explained that it was his third child. There was a conversation underway quite rapidly about what the child was doing, about sleeping, about eating, and the nurse was making comments, but in the meantime the baby was put on the living room table with a blanket and the nurse began to undress it and to examine it. She showed how skilled she was with a child, looking at the child's eyes, talking to it, gradually undressing it, playing with it, touching it, feeling it. She paid particular attention to the swollen part of the thigh since the child had had an inoculation the previous day and was obviously swollen and uncomfortable. The nurse explained what happened and how to deal with it, talked about use of lotion, and gradually looked the child over. The father was joining in and making comments periodically. In effect there was a good deal of modeling, play with the child, talking to the child, touching the child. She then wrapped the child in a towel sling, took out the "famous" Danish nurses' scale and weighed the child. The child began to cry because it was clearly uncomfortable. In no time at all she had it cooing. She then used her tape measure to measure the child's body length and head size, writing all this into the baby book which the mother had presented when the conversation started. (The impressive "baby book", kept by the mother, is universal.)

The nurse looked at the measurement results as compared to the last week and commented on the adequate growth. The parents did have one thing to divert and calm the child, a rather ingenious music box/toy. The parents commented about an item in the newspaper this week saying that one in ten Danish children are underfed. We asked what reasons were given by the paper and they said that part of it was problem families who didn't feed children adequately and part of it was families with adequate resources that didn't give the children the right food because they picked up one food fad or another about avoiding excess milk and butter, etc. The nurse then took advantage of this to talk about how excess nursing and giving of milk could deprive the child of other needed food and minerals for balance and how important it was to really be aware of the quantity of milk the child was getting.

Something about the child's development as described by the nurse led the parents to bring out a picture album where they showed the child's picture. In the meantime, in weighing and measuring the child the nurse had placed it on its stomach and the child had raised itself very effectively on his arms. The father was obviously very pleased to hear a comment about how strong his little son was. The father took occasion to turn to us and to ask what we were was seeing in Denmark and whether we would be visiting Louisiana, the museum not far away, and he mentioned the current exhibit.

Then, with the nurse's entries made into the book, and the child dressed and in the father's hand, the parents began further animated discussion about what the child was doing and how the mother was behaving. It then developed that the reason that the father was home was that the mother had been up practically the whole night with the child and felt exhausted and he had taken a day off work in order to help her. Later the nurse was to tell us that all the questions raised and all the suggestions given were a repetition of previous visits. This is a very anxious mother. She does not seem able to respond to the child's signals. She has started in a mothers' group. The nurse hopes she will get something from it. In this connection it was explained that a new mothers' group is started up every six weeks and they invite six or seven mothers to the group, and the nurse participates with the group for about three times on alternate weeks. Then the mothers take off and meet alone in a supportive relationship.

The emphasis in the mother groups is on support and interaction of the women with one another, rather than didactic content. However, the nurses will respond to a request for a talk by an expert on a particular topic. In addition, this nurse has begun a father's group (much more rare) and it has gone very, very well. The four fathers have been meeting weekly, enjoying talk with one another and they seem to talk about the same things that the women talk about, e.g., how it is to be in a family, how the family is changed by the arrival of the child, etc. They have developed a strong group which now has been meeting weekly even though they started bi-weekly. They sometimes in these groups raise questions about their older children, too.

As we left the first home, the nurse indicated further insight into the family. She said that the father has visitation rights with his two children who now visit every other weekend and twice during the week briefly. The mother finds this excessive. She wants to be alone with her husband and her young child. They have not resolved this, and the nurse is aware therefore of an internal family problem.

She hopes in general that she can get the mother to cope with the difficulties by acting differently herself with the child. And that she will get various supports from the mother's group so that she will be calling other women about her daily anxieties and doubts and being reassured by their responses, rather than being dependent on constant calls to the nurse. The nurse also said that this was an unusually disordered and unclean house. The others in this area are modest in the same way, but tend to be cleaner.

The second house is in a very different area. One rode about eight kilometers along the shore to a very beautiful "new town" arrangement in which the parking keeps the cars away from the area where the houses are, and the children and adults walk on winding roads in a well-planted decorated area with trees, bushes, and flowers. It is a picture-book middle class community which shows Scandinavian town planning at its best. The middle class homes, all quite modern, although not especially large, surround a pond which is circular and has one area of water lilies. (Because of the potential danger to wandering children, children who are away from the home and not with adults are required to wear life vests as they play around the pond.) In contrast with the first family, according to the nurse, she was taking us to a picture-book situation, beautiful community, beautiful home, middle class comfort, and a teacher - engineer couple, each of whom was in turn functioning well and also very good looking. This family have a 2 1/2 year old, so that this is a visit to a second child. She had come one week ago and was now making the second visit, with permission, so that we might observe.

At the time of the first visit she had checked mother and child physically, checked the child's reflexes, mouth and ears, and saw absolutely nothing wrong and no excess anxiety. She stressed, however, that the fact that she saw nothing wrong and saw no excess anxiety or social problems, did not mean that the parents have nothing to talk about. This mother had a lot to talk about, both about breast feeding questions and about some physical problems she had as a result of a tear in the peritoneum and the need for a healing process. Thus the breast feeding and the tear proved to be the big subjects of discussion.

When we arrived the child was out on the terrace sleeping in the baby carriage. A beautiful cat was wandering around the well-furnished apartment. It should be stressed that the apartment was not orderly in a very, very tight way. Things were strewn around, and there was obvious comfort in the use of the place. We sat in the living room, couch and chairs, around a table, were served cold fruit drink, and the nurse and mother began a long conversation. One part of it dealt with what the child was doing and how, and then it turned to the various problems of the mother. There was plenty to talk about. The nurse turned the pages of the baby book, got up to date on the situation, asked a number of things, and the mother gave additional information that was entered. She told about how different she was finding this second child. With the first, for example, she got very little sleep at the beginning. Here, in contrast, she slept for six hours last night. This child was only 2 to 3 weeks old. She herself interpreted it as meaning that she was more relaxed, the child was more relaxed and the child was sleeping. Also the child seemed to be getting adequate food and was not waking up for food earlier. In contrast to the first mother who did not introduce very much about herself but did tell us her first name (second names were omitted specifically for purposes of confidentiality), this one described herself specifically. As the conversation went along the mother introduced several issues about the child and about herself, and told many anecdotes about her past and about her present. The nurse occasionally commented or raised a question.

This went on for a half hour when the child in the carriage awoke and could be heard crying a bit. The mother picked up the child, handled it with comfort and expertise and the child was obviously comfortable with her immediately. She said that the child seldom cried. We then went into the parent's bedroom where they had a special baby crib, a beautiful changing table, and a series of cabinets and shelves for the various materials. The diaper was easily changed and the child cleaned, and the nurse took over for her examination. She did less of the handling of the child and communicating with the child than she had in the first room, given this mother's great competence and the child's comfort in the mother's arms. Thus, in much less time she weighed the child and measured it and entered the material in the book. The mother had asked a question about the child's skin color and she gave an answer in relation to the physiology of the birth process, and then the mother began to nurse the child while the nurse was explaining something about distribution of milk and how to tell how to make a switch to the other breast. The nurse also answered some of the mother's questions about treating her sore pelvic area and how she could heal more rapidly.

In short, here were "beautiful people", well situated, without problems, and yet they had a lot of service from the nurse in this "normal" universal service. One could only agree that it is a "wonderful service". One was also aware of the fact that this is a universal service, but not an intrusive one. We did not visit until permission was given. The mother took the initiative in suggesting when the next visit would take place, but the nurse told what the usual frequency is, at which times she could manage it, and they had no difficulty agreeing on a date. In the first situation, they negotiated because the mother wanted a visit earlier. This mother was having no problems, but she did readily accept information about when a mother's group would be starting up and she would join it. She joined the mother's group with the first child, but did not continue. Some of the women continue for a long time, some get what they want quickly. This was a very competent young woman, a teacher, who would go back to work when the child was about 6 months old and would use child care resources.

The 2 1/2 year old was in a day nursery while all this was going on. In one corridor of the house was a large wall area with a kind of bulletin board and all of his productions in the day nursery were posted,as were pictures of activities and of others in the day nursery.

The next visit was scheduled for three weeks ahead. As we left the nurse indicated that "all families here (in this area) are like that", they are in good shape, but they use the service in ways that are appropriate for them. Most of the Helsingør families are like the first, in the sense that they are not exceptionally well off and they have more problems and issues. The homes tend to be a bit cleaner. But in this area we have more fortunate families.

Field Visits with Home Health Visitor, HHS

This family had two children, a 3 year old boy who is now attending a kindergarten and a 4 1/2 month old boy. In effect this was a nurse's routine visit to a family with a second child. The focus of the visit had to do with food, introducing the baby to solids, in a context of a history of extensive allergies in the family. In addition, the mother who is a *pedagogue*/ social worker, was planning to return to work in a child care center in another six weeks, and so another focus of discussion would be plans for child care.

In this context, comments were made en route about the really serious shortage of child care services in Helsingør. The parents who work in this community tend either to work locally or to commute to Copenhagen, but they have a problem with child care for the very young children. A family day care home may be available, but the nurse indicated that the women who do child minding are not well educated and in her view the quality of the care is not really good. Parents prefer center care, and there is a shortage of such places until children are about 1 year, or 1 1/2 years old. As a consequence there is a real problem for the working mothers who are returning to work when the child is 6 months old and seeking appropriate care.

The nurse indicated that if all went well on this visit and there were no problems, her next visit would be when the baby was 8 months old. She explained also that the father, who is a *pedagogue* as well, had had a back problem and had been home on sick leave for a while but was now back at work.

The apartment was located in an old low-rise building just off the walking street in the center of town. The nurse described it as a "cheap" apartment, something that the young couple were able to afford, but it was not really satisfactory. It was on the second floor of a walk-up, and included four rooms, a living room and two bedrooms and a kitchen. The rooms were small, the furniture rather sparse and probably hand-me-downs, and the organization of the apartment was such that one came up into a small entry of a small living room, the bedroom was located off the living room as was a kitchen, and the second bedroom required going through the kitchen to reach. There was one bathroom. The master bedroom was a room that was off the kitchen, but had now been given over to the two children while the parents took the smaller bedroom off the living room.

When we came in, we sat at a table in the living room and the entire discussion and visit was conducted there. It lasted about 1 1/4 hours.

The entire discussion went on in a very informal manner in the living room with the mother holding the baby, putting the baby up on the table in a baby seat, putting the baby - briefly - in a small crib behind the table, and later on having the baby playing with a friend. The baby was with us the entire time and clearly the center of attention. This was an extraordinarily responsive 4 1/2 month old who was very vocal and who cooed, giggled, responded to every look and every indication of anybody's voice in the room.

Much of the discussion between the nurse and the mother went on in Danish of course, but the mother spoke English and periodically they would shift into English to be sure the visitor understood.

The nurse went through what we soon decided was a standard routine: she took a tape measure and measured the size of the baby's head. Using the tape measure she also measured the height of the baby. Using her special scale she weighed the baby in this case by knotting the diaper at 2 points in order to make a kind of sling and then holding the baby up with the scale and weighing it. She then took both her hands and ran it down the side of the baby's head looking in the baby's eyes, nose, mouth, examining gums and so forth. She subsequently undressed the baby and carefully felt down the side of the baby's body, the stomach, looked at the legs and whether they were straight or not, all the time talking to the baby and watching for responses.

Present during the entire visit was the 3 year old little boy who had been kept home from kindergarten specifically because he wanted to be present when the nurse came to see his brother. He had known her from before and he wanted to participate in this visit. The mother talked about how she has tried to keep the 3 year old home or involved in anything that's special for the baby and feels that there has been a minimum of jealousy as a result. On the other hand, it was also clear that the 3 year old wanted attention and periodically got involved with some things that he was testing with, such as eating a lot of candy when the mother was involved in the discussion with the nurse. The nurse spent some time talking to him and made him feel part of the process as well.

In addition to the routine examination, the nurse and the mother focused on the issue of how to handle introducing the baby to new foods, given a history of allergies. Apparently the family has such a history; it's particularly severe for the father who tends to get various kinds of skin reactions and rashes from a variety of items including pollen, various foods and so forth. The baby, who is an exceptionally happy, responsive, but is also fat and round was keeping the mother up at night steadily because he would want to nurse very frequently.

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The nurse suggested that this indicated he was not getting enough food, and therefore it was particularly important to start him on solids. They agreed that he would start on some kind of a cereal and that the mother would wait a month to see how he tolerated it before then introducing him to any other kind of solid food. In addition it was agreed that certain foods would be avoided as being particularly likely to lead to allergic reactions.

The mother talked to the visitor about how her sister had a baby that was born a day later than hers and how her nephew was so physically active and was able to do all sorts of things involving physical movement while her baby was not. She attributed this to her baby's being fatter. The nurse without any other kind of comment asked her if the baby gets much opportunity to crawl around the floor. The mother commented that for the first child she had had a playpen in the living room, but since she had given up the master bedroom to the two children and more of her things were now in the living room that there really was not room for a full sized playpen. The nurse suggested that when the mother was not cooking or involved in some other activity, when the child needed to be in a protected environment, that she give the child opportunity to be on the floor and to crawl around more. It was clear that in a non didactic manner this was really a way of recommending that the child have more opportunity for physical movement.

The child, as indicated earlier, was the center of the mother's attention during this discussion. Quite appropriately and responsively she held her baby, she talked to the baby, she kissed the baby, the baby was part of the conversation; when he was put in the baby seat on the table, one had a sense of a delightful child and a very good mother-child interaction. When the baby started to fuss the mother nursed him and then put him in a small crib nearby. Sometimes in the course of the hour, a friend arrived and then played with the baby and with the older child, as well.

All of this was going on in a seemingly informal discussion in which nurse and mother interacted as if they were friends although it was quite clear that periodically the nurse would interject advice from a position of expertise.

There was then some discussion about when the mother was expected to return to work. She plans to return at the end of her six-month leave and would be working full-time, although full-time in her job means 9:00 a.m. to 2:00 p.m. except for certain periods in the year when she may have to work very long, e.g. twelve to eighteen hour days. She has other family members who can help out at such times; it means that neither child would have to be in a long-day program most of the time. However she complained about the problems of the inadequacy of child care, the fact that she was on a waiting list and that what she was going to do was work out a series of informal arrangements. The friend who arrived in the morning would be home for a few months attempting to work out some problems with a handicapped child. While that friend was at home, during August, September and October, she would care for the baby. After that they would arrange something else but are not sure just what.

The nurse jotted down a series of notes in the baby's journal and then they discussed the subsequent visit which was scheduled for October. The general concept was that the baby was doing very well and everything was fine, that the mother would introduce solid foods and monitor it and if there was any problem she would call the nurse. A reasonable plan for child care for the first few months was in place, and a next visit was scheduled.

The second visit that morning was in a different kind of an environment and in a different kind of a situation. This was an "extra" visit to a baby who had recently had his 1 year visit. It was really the mother who was the focus of the visit rather than the baby.

This is a mother in her 20s who had a relationship with a black South African with whom she had this baby, and then he left her. She has subsequently become involved with a second black South African male who is apparently rather traditional in his attitudes towards gender roles and he does nothing to help in the house or to help with the baby. Nonetheless, the mother is anxious that the relationship not break up and so she does not ask him for any kind of help and she is very depressed. In addition, the mother had wanted to stop breast feeding, but the child did not, so she was having difficulty figuring out what to do.

She had been offered some kind of psychiatric or psychological help previously and had made an appointment but then did not keep it. Similarly, she had been encouraged to participate in a mother's group and made plans for it and did not follow through. The nurse was really concerned about how the mother was functioning and what the implications were for her child and his development.

This mother also was a trained *pedagogue* and a professional staff member in a kindergarten. In contrast to the first apartment, this was a very attractive apartment in subsidized housing in a suburban part of Helsingør. It also was a four-room apartment but much more comfortably designed, much more spacious than the other apartment and much better decorated with better furniture. Despite the fact that in effect this was a single mother, getting some assistance from the community, living with a man who was a student and providing no financial support for her at all, she was living very comfortably. The apartment was very well decorated, had lots of books, had a small terrace with flowers and plants and was well kept.

The 13-month old little boy was a charming interracial youngster with an extraordinarily well developed physical capacity and sense of coordination. In the one hour and a half of the visit, this youngster practically never sat still. He played with a ball, he climbed up on a chair, he climbed up on a table, he climbed up on chairs and tables on the terrace so that at one point both the nurse and the visitor raced outside thinking he was ready to climb off the terrace.

In this apartment, as on the earlier visit, coffee, cookies or cake was served and it was clear that when the nurse come it is considered a special occasion and something of a party. The mother explained that the baby had had a stomach virus and was just recovering. She also said that the baby had given up breast feeding during the night and was now drinking from a cup. Indeed on several occasions the youngster came up and clearly wanted something to drink and took milk from a cup. The nurse commented to the mother when there are stomach viruses, it is usually better to defer having milk until a complete recovery. The mother agreed yet nonetheless continued to give the child milk throughout the time we were there. The nurse said subsequently that the mother really knows this, but nonetheless was not able to respond to what was appropriate because she has her own problems.

In some sense, just as the baby seen earlier was extraordinarily vocal and responsive, but not so active physically, this youngster represented the reverse pattern. That is, he was an extraordinarily physical child and very responsive but clearly not yet ready to talk. Indeed it later turned out that one of the things that the nurse did was to ask the mother if she talks much to the child and to try to encourage her to talk more since she, too, recognized that the child was not vocalizing as much as one might expect at this age.

The mother's affect was very constricted and subsequently the nurse said that she thought the mother had probably experienced a post-partum depression. Nonetheless, the mother was normally responsive to the little one, although not always most appropriately. Thus the youngster went back any number of times to some of the shelves where there were books and various kinds of objects and persisted in taking things off the shelves. The mother kept putting them back and finally snapped at him that he should not do that. The obvious issue had to do with whether she should not be removing some of the things from the shelves in reach, given the child's clear curiosity and activity.

The nurse went though the same examination she had gone through before, namely the measuring of the head, the measuring of the length, the weighing of the child (this time by tying the diaper under his arms and holding him up on the scale). The child was clearly in wonderful shape physically, quite beautiful, but wriggly and difficult to contain. Obviously he was a handful for his mother, physically very demanding. She was finding it difficult to respond to him.

The mother simply said that she had forgotten the appointment with the psychologist, and that is why she had not gone. She also indicated that she had been depressed and had not followed through on the mother's group. There was further discussion and she said that she really wanted to be part of a mother's group and would participate in whichever one was available next.

Part of this visit had focused on trying to assess the mother's condition, the extent to which she was able to meet the child's needs, whether the depression was beginning to lift and so forth. Another part verified the situation of the child who clearly was in very good shape and an enchanting little boy, regardless of whatever problems were going on in the household. Still a third focus that emerged in the discussion was the nurse's recognition of how much more active the child had become even in the last month and advising the mother about the importance of developing some sort of physical safety protection on the terrace so that there should not be an accident.

Discussion

After the visits we talked to the two nurses together. One part of the discussion had to do with the mother's groups. Every two months a new group in the same neighborhood and with the same aged child is organized. Some of these take hold and they last for years, but some last only briefly. The nurse meets with them for the first three sessions and then leaves the group to sink or swim on its own. If the mothers are at home, during the post-childbirth leave, they may meet weekly; however, once they return to work there tend to be evening meetings and these may be less frequent. The main focus, as said earlier, is on social support. If there is interest in special subjects, there may be other professionals who will come and talk with them. The mother's groups that HSS organizes meet at this office for the first three times and then meet at one of the mother's homes. There is another group that meets in a local school, some meet in churches and so forth.

We asked about the number of visits they make to families each day and were told typically it's three to five but occasionally as many as six. They visit the school that they are assigned to once each week. Whether it's to the school or to the family it's a very popular service. They devote four or five hours to a school visit, in effect a full day's work.

When we commented that they seemed to be enjoying what they were doing, both said that the people they are visiting are happy to have them, because they are doing something specific and concrete for them, and it is the response that makes it enjoyable work.

We asked about their own backgrounds and were told that SV has worked for ten years at this office. HSS, in contrast, began at a small commune in the south of Denmark and the local municipality sent her for special training as a public health nurse. She worked for two years in the community after she got that training, but found it very isolating because she was the only staff member there. When an opportunity arose for her to get a job in Helsingør, she took advantage of it because her parents live here as do a brother and a sister.

We were told that most nurses are about 30 years old, obviously mature individuals, before actually beginning their practice, in effect even older than professional social workers. This is because their training is quite extensive. They get trained as nurses, have a required period of practical experience in a hospital, and then get a one-year public health course. In effect this is five to six years of training.

Both of these nurses have young children. SV had a 10 month old and HSS has three children of whom the youngest is 2 1/2. They both talked about the problem of child care. HSS pointed out that the 13 month old boy she had visited would not have a place in child care for one more year and that was really not good for him. In effect she would try to do something about it but was not sure what could be done. We had been told that the first mother HSS visited had gone through three family day care mothers with her first son and was not satisfied with any of them. Then, as she put it, "fortunately" her brother-in-law had become unemployed. He had three children of his own, was good with kids and while unemployed cared for her son until a place in child care was available at which time he then he was able to get back into work.

We were also told that this is a community in which there are a significant number of immigrants and refugees. There are special programs for them. Indeed there is a special program for women refugees that operates from 8:00 in the morning to 1:00 p.m., teaching Danish and various other kinds of subjects to Arab, Lebanese, Iranian, or Pakistani women. Sometimes there is a problem because their husbands don't want them to learn. They want them to stay at home and be submissive, but the women become increasingly oriented to alternative lifestyles and want at the very least to learn the language. In this context we were told that Moslem women accept the idea of the home visit, but have a tendency to either forget or ignore the appointments. This we were told is true for Gypsy women as well. Even when the visits are made, the nurses feel that they are not sure how much of what they want to convey gets through. If the mothers speak Danish there is no problem, but in many of these households the men speak Danish and the women do not. As a result, the father is doing interpreting for the nurse and the nurse is convinced that the interpretations are skewed. They are now beginning to use their own interpreters in order to be sure that the right messages are getting across.

In response to our question they talked a little bit about hard to reach families. These, once again, tend to be either immigrant families or refugee families or families with very young mothers. They try to convey a message that even in situations where the parents may be inadequate and neglectful, they know that the parents want to do what is best for their children. Thus the nurses focus on this goal which they can support, but attempt to interpret what it is that might be able to be done to help the situation. They tend to use their authority in these situations. Thus they may tell a parent that the problem with a child is a serious problem, but that if they cooperate with the nurse, the nurses will attempt to support them and to work within the framework of the parent's preferences. If the parents do not cooperate, then the child will be removed. They believe that the important thing is gaining the confidence of the parents early on and then working with this trust relationship in order to effect certain kinds of changes.

Finally, they talked about the fact that they do have a telephone period during the week. Mothers can and do call them, and some insecure mothers tend to call frequently, but nonetheless this is an important supportive service.

We commented that from what we had seen they really were using a lot of medical knowledge, e.g., responding to the swelling after inoculation, measuring the child's head, discussing with the mother her physical healing after the birth, dealing with a bloated belly that the mother was concerned about. They stressed how important it was to be a nurse and to have nurse experience, and commented about the efforts in some quarters to substitute *pedagogues* for nurses in the home visiting program.

CONCLUSIONS

Denmark has a family policy focused particularly on families with children. In recent years, this has meant very young children, infants and toddlers especially. While not located in one place in government, the policy has emerged from the work of several commissions and the parliament, and is guided and supported currently by a broad interministerial committee. Much of the actual implementation, the shaping of service programs and the delivery of benefits, is through municipalities in Denmark's highly decentralized system of public administration. This, despite national government leadership. Indeed, except for a component (but the minor portion) of child care services, most of the delivery network is statutory.

Denmark's comprehensive, high-quality, high-take up programs reflect a philosophy of universalism and a belief in social entitlements. Most programs, even the core pensions, are non-contributory and flat-rate, reflecting solidaristic values and the belief that all citizens should have equal treatment independent of market status. Thus Denmark has a health service, not health insurance. With reference to families with children, it spends more on services than on cash benefits, a pattern characteristic of Nordic countries in which Denmark leads. While the Social Democrats are the largest single Danish party, Denmark has been governed by coalition cabinets with conservative prime ministers since 1982, the very period when policy for young children has been expanded and strengthened. Despite increased debate and some sharper polarization of late, the child policy components are firmly anchored and enjoy broad public support. This support in significant part reflects, among other things, Denmark's extraordinarily high rate of female labor force participation, including participation of mothers of young children.

The core exemplar elements of the young child policy in Denmark are child care (whether family day care or center care for infants and toddlers) and home health visiting in the first year of life. The former is of high quality and offers coverage rates unmatched in northern and western advanced industrial societies. The latter is the most intensive service model of its kind, offering case finding, referral, family support, advice, focused on both health and social dimensions, and well linked to other service systems.

These components are anchored in a broader, if less exemplary, policy offering modest child and family allowances, advance maintenance payments for single parent families when the non-custodial spouse does not pay child support, maternity/ paternity benefits for approximately one-half year and a recently inaugurated supplementary parental benefit, a health service, and some beginnings of family support services.

To the extent that current debates suggest opposition to these policies or some desire for change, it comes from conservatives, who seek not dismantling but a curtailment of growth in public expenditures, and from a libertarian group. There also are those generally sympathetic to the thrust who worry about government's assumption of extensive obligations to a point where family responsibility is undermined (care of the frail elderly out of family hands and assumed entirely by government; children in care long hours while both parents work long hours and are said to be too tired to relate properly to them). Nonetheless, the solutions urged by most of those queried in surveys involve somewhat shorter work hours, not the giving up of child care or an emphasis on at-home parental care which one now sees in Germany and Finland, for example. On the other hand the child care programs themselves reflect a desire to play a sound role, alert to the children's social milieux: the philosophy stresses offering children in care an environment and adult staff skilled in creating emotional warmth, support, and simulation for self-expression and individualized development, without pressure to "learn". This is accompanied by a shift from age-based to age-integrated groupings which approximate family socialization, and the absence of emphasis on formal instruction. "Age-integrated", however, is interpreted and implemented in several different ways. At the same time a legislative requirement for stronger parental representation on the boards of child care centers has been passed and is being put into practice. There is also discussion of somewhat more extended parental leaves, of better benefits to remain at home to care for a sick child, and of seeking a way to shorten the work day of parents of young children. The examples of Sweden and Finland are visible.

NOTES

[1] Jorgensen, 1991, p. 5.

[2] Ibid.

[3] Johansen, 1988, p. 303.

[4] Bartiaux, 1991.

[5] T. Knudsen, p. 69.

[6] Dumon, 1991, p. 70.

[7] In 1992, 1 DKK = $ .166. The child allowance amounts are as reported by Eurostat.

[8] Johansen, 1988, p. 324.

[9] Knudsen, 1988.

[10] Jorgensen, 1991, p. 12.

[11] European Commission Child Care Network, Leave Arrangements for Workers with Children (Brussels, Belgium: European Commission, 1994).

[12] Jorgensen, 1991, note 4, p. 33.

[13] Kamerman and Kahn, 1991.

[14] Kamerman and Kahn, eds., 1991.

[15] Jorgensen, p. 19; also f.n. 6 on p. 34.

[16] Johansen, 1988.

[17] Johansen, pp. 314-315.

[18] Jorgensen, 1991, p. 15.

[19] Jorgensen, 1991, p. 16. After-school care not included.

[20] Danmark Statisik, Statistiske Efterretninger, 1993:12, Table 5. Also see, Langsted and Sommer, 1993 and Moss, 1989.

[21] Vedel-Petersen, 1992, p. 7.

[22] Vedel-Petersen, 1992, p. 8.

[23] Vedel-Petersen, 1992, p. 9.

[24] Jorgensen, 1991, p. 17; Vedel-Petersen, 1992, p. 57.

[25] In purchasing power parities, this total income would probably purchase in Danish comsumption about what a $47,000 U.S. income might.

[26] Vedel-Petersen, 1992, p. 176. In this section, whenever we refer to Vedel-Peterson, who *published* in 1992, we apply 1991 currency exchange and purchasing power parity rates. On the other hand, in converting information obtained in interviews we use 1991 or 1992 rates, depending on the dates of interviews or program visits.

[27] Vedel-Petersen, 1992, pp. 13-14; and *Yearbook of Nordic Statistics, 1992*.

[28] Vedel-Petersen, 1992, p. 16.

[29] Langsted and Sommer, 1993, and Ministry interview, May, 1991.

[30] Vedel-Petersen, 1992, p. 17.

[31] Langsted and Sommer, 1993, p. 160.

[32] *Ibid.*, p. 163, Note 1.

[33] Interview, May 1991.

[34] Vedel-Petersen, 1992, pp. 20-51.

[35] Vedel-Petersen, 1992, p. 21.

[36] Bengt-Andersson, 1986.

[37] Langsted interview, June 20, 1992.

[38] Vedel-Petersen, 1992, pp. 25-26.

[39] Vedel-Petersen, 1992, pp. 25-26.

[40] Interviews, June, 1991.

[41] Jorgensen, 1991, pp. 23-25.

[42] Jorgensen, 1991, p. 25.

[43] Langsted and Sommer, 1993; Qvortrup, 1990.

[44] Langsted and Sommer, 1993.

[45] Langsted and Sommer, 1993.

[46] *Yearbook of Nordic Statistics, 1992*.

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[47] There are modest variations in precise percentages depending on source, date, definitions. Denmark was reported (Child, Family, and Society, 1992) as having the highest E.C. labor market participation rate for women in 1988 (Sweden, not in E.C., is a bit higher). The Danish rate of 87 percent includes 8 percent unemployed and 32 percent part-time. This report states that of mothers with children under age 5, some 75 percent were employed, and this total is made up of 46 percent full-time and 28 percent part-time. The figure for lone mothers is 70 percent. In the summer of 1992 the rate of 92 percent was cited for all women.

[48] Ribes, 1991, pp. 142-144.

[49] Elgaard, Langsted, and Sommer, 1989.

[50] Johansen, 1988, pp. 342-345; OECD in Figures, 1991; Hemmingsen, 1990, p. 8.

[51] The Nordic Countries, 1991, p. 11.

[52] Ribes, 1991, pp. 41-71.

[53] Jorgensen, 1991, p. 27.

[54] Jorgensen, 1991, note 12.

[55] Plough, 1991.

[56] June, 1991, interview.

[57] Vedel-Petersen, 1992, p. 56.

[58] Kamerman and Kahn, 1991, pp. 4 ff.

[59] Kamerman and Kahn, 1991, Tables 1-11.

[60] Ibid.

[61] EUROSTAT, 1991.

[62] Nordic Social-Statistical Committee, 1987, p. 15.

[63] Johansen, 1988. We rely heavily on Johansen in this section, as updated by interviews, summers of 1991 and 1992, and various comparative E.C. materials.

[64] Specifics in Johansen, 1988, pp. 298-299. Earlier quote on p. 299.

[65] Vedel-Petersen, 1992, p. 177.

[66] Johansen, 1988, p. 325.

[67] Johansen, 1988, pp. 249, ff.

[68] The Social Democrats assumed the Prime Minister portfolio in 1993.

[69] T. Knudsen, 1991, ch. 1.

[70] Previously parents could be assessed up to 35 percent of child care costs. The 1991 compromise changed this to 32 percent. It became 30 percent in 1993.

[71] The Social Democrats advocate free child care. In Social Democratic Copenhagen the parental share is 22 or 23 percent.

[72] Jensen and Langsted, 1988.

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SOCIAL POLICY AND THE UNDER-3S

FINLAND: A CASE STUDY

Table of Contents

PAGE

INTRODUCTION ....FI 4

CHILD AND FAMILY POLICY - AN OVERVIEW ....FI 6

THE UNDER-3s IN FOCUS ....FI 11

1. Child Allowances and Tax Concessions..........FI 12

2. Prenatal, Maternity and Postnatal Care........FI 14

Background ....FI 15

3. Maternity, Paternity and Parental Leave.......FI 24

4. Child Care or a Home Care Allowance...........FI 26

5. A Shorter Work Day............................FI 29

6. Child Care Programs...........................FI 30

CONTEXT ....FI 38

1. Demography and Labor Force Participation......FI 38

2. Expenditures ....FI 42

3. Political Environment.........................FI 46

ON THE GROUND - CHILD CARE...........................FI 48

1. A Tapiola Child Care Center ....FI 51

ON THE GROUND - MATERNAL AND CHILD HEALTH ....FI 71

1. Kirkkonummi, Finland ....FI 71

2. The Child Health Center ....FI 80

CONCLUSIONS..FI 84

NOTES ....FI 87

REFERENCES ....FI 89

List of Tables

PAGE

Table FI-1 Child Allowances, Finland, 1992 and 1994...FI 12

Table FI-2 Social Expenditures, Children and Families, 1989....................................FI 44

INTRODUCTION

Despite its relatively late industrialization, Finland has enjoyed remarkable economic growth since World War II and, directly influenced by its Nordic neighbors, has developed a welfare state which features universalistic strategies. Finland shows the Nordic commitment to the concept of the "people's home", a society in which everyone is precious and should be given opportunity. The concept of the "welfare state is essentially accepted by all political parties."[1]

Policy also is very much influenced by one of the preconditions of the country's economic growth, the highest (or one of the highest) female labor force participation rates among the pluralistic democracies, much of it full-time. In this context, child and family policy has had strong political support. The need for child care arrangements has resulted in a rich array of guarantees and options, making Finland's under-3 policy particularly worthy of note. Income supports, child care options, preventive health services and a generally high standard of living have placed Finland among the two or three top countries in the world in its infant mortality record. It is almost free of child poverty. And, until the severe economic depression of the early 1990s, it had committed itself to further improvements in its policies and programs.

In recent years reorganizations have placed planning and policy development in a single ministry combining health and social welfare concerns and joining both income transfers and services (Ministry of Social Affairs and Health). A related National Research and Development Center for Welfare and Health, subsidiary to the Ministry, has Research and Development, research, data collection and some residual administrative responsibilities. There is no specialized agency for family and child policy, nor is there an integrated plan. Nonetheless the concept of family policy (to include children) has been widely used in government and in public discussion. Policy initiatives and coordination reside in the Social Affairs and Health Ministry. Implementation of services is assigned to lower tiers, largely the municipalities, which have become particularly important recently, especially with regard to child care policies. The intermediate provincial level has also been becoming more important, especially in the health field.

Following the break-up of the Soviet Union, Finland - long constrained by the political requirements of its location and defeat in World War II - has begun to reposition itself in the wider political sense. It no longer must depend on government by consensus, and it has sought entry into the European Union. A coalition of conservative and center parties has taken over the government completely, there are no Social Democrats in the cabinet for the first time in twenty-five years, and the government is dominated by the type of market ideology characteristic of the Reagan-Thatcher era.* A decline in the economy (including the loss of a U.S.S.R. market that had absorbed 20 percent of all exports) and unemployment, in the context of European recession, have presented new challenges for which modern Finland has few precedents. There are serious budget constraints. Thus far, however, child and family benefits have not been cut back significantly and the prior basic policy thrust has largly been sustained.[2] As will be seen, Finland's child policy gives special attention to facilitating at-home care of the under-3s and ensuring child care resources when that option is preferred. The infrastructure provides a superior maternal and child health program and an internationally recognized record of child health.

CHILD AND FAMILY POLICY - AN OVERVIEW

We begin with a listing of the total policy package. The items which are starred (*) will subsequently be elaborated as

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[*] Early in 1994, well after the completion of this "case" and in the midst of serious economic depression and high unemployment, a Social Democrat won the presidency.

part of the under-3 policy. Finland prides itself on the development of the package which is considered to be responsive to a pattern of family life with many two-earner families and single mothers who are employed. Much of family policy, it will be noted, is child policy.

* - Child allowances, universal, increase with the child's ordinal position in the family, They are tax-free and paid until age 17. They are modest for one or two child families, as specified below.

- Prior to 1994, families received tax deductions for all children under age 18 in the municipal personal income tax system. It was a flat rate deduction, favoring low income families. There was an "extra" deduction of 8400 FIM ($2,075) in the state progressive tax system for children ages 3-7, of greater worth to higher-income taxpayers. There was a deduction of 10,500 FIM ($2,594) per child in the municipal tax system. Child support payments were also deductible, but to a low maximum (1450 FIM or $358 per child per year). Lone parents were granted an extra municipal tax deduction (12,500 FIM or $3,088), which did not vary by the number of children.* As a short term austerity measure, the government decided to emphasize direct benefits (child allowances) effective 1994. The child tax deductions were abolished: the special 3-7

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* Most of our cost and benefit data are for 1991 when the marka was equal to U.S. $ .247. In purchasing power parities, OECD reported the marka = $ .159.

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deduction, the municipal deduction, the lone parent deduction.

- A lone parent who is divorced or separated, or who has a child out of wedlock, is entitled to child support from the non-custodial parent. If that support is not paid, or if paternity has not been established, there is a public child maintenance payment (worth about 6 percent of an average wage in 1992). This payment is neither income-tested nor taxable. It is an addition to the child allowance. In 1992 some 86,000 children were beneficiaries of child support payments, some 56,000 receiving payment via the public guarantee in the course of the year.[3]

* - A statutory universal maternity and child health care program is administered by the municipality. There is no means test and the program's core principles are: close contact with families, continuity, and free service. The entire population is covered by sickness insurance which includes both the costs of medical care and compensation for lost earnings. While most people use this public service, there is the alternative of private insurance for payment of medical care fees (with deductibles and co-payments). Many people use the option for some purposes but the public system gives most of the care.*

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* Finland also has an extensive occupational health care system and a separate (free) system for university students.

* - A maternity allowance is subsumed under sickness insurance. The father may claim a portion of this as a paternity allowance if he - rather than the mother - remains at home to care for the baby. Either may use an extended parental leave and benefit which follows.

* - An employed parent in a two-earner family may claim 4 days of leave to remain at home to care for a sick child under age 10. Collective bargaining arrangements ensure about three-quarters of such parents full wage replacement for the days taken, while the others have less or no wage replacement.

- What is called a child care allowance is a social insurance benefit for children under age 16 with severe handicaps, to provide them with the constant attention and supervision they require. The statute sets monthly payments based on the "degree of helplessness"; these payments are tax free.

- An extensive, but not yet quantitatively adequate system of kindergarten and day nurseries provides developmental services and care for children ages 3-6, and municipalities are mandated to guarantee sufficient space to meet all requests by 1995 (unless current economic problems lead to some postponement).

* - Since 1990, municipalities have been mandated to provide day care (centers or municipally-managed family day care) for all children under age 3 whose parents request the service. Day care is one component of a home care

allowance policy package allowing the parent the option of out-of-home care, in-home care, and a cash grant which may be used for other arrangements. This cluster is the pride of Finnish family policy.

* - Since 1988 parents have had the right to shorten their working hours to care for at-home children under school age. If the at-home children are under age 3, a partial (25 percent) home care allowance is payable. Take-up, thus far, is rather limited.

* - Time at home caring for a child under age 3 and receiving a home care allowance is considered labor-force time, so that (since 1991) pension credits also accumulate.

- A hot meal at mid-day for each child daily whether in day care or in school is another child policy item which Finland values.
- Housing allowances are provided to low-income families who rent or own standard housing and whose costs exceed a fixed percentage of income. In 1988 some 89,000 households, of which 40 percent were lone-parent households (46 percent of all lone parents), received such allowances. The depression raised the number to over 150,000 in 1991, including half of all lone-parent families.

The deductibility of interest on housing mortgages in both the national and municipal tax systems, available to all families, is a far more important benefit in terms of overall costs.

- Widows, widowers, and children receive survivor's pensions under the social security system, as is the case in most social security systems.
- There are earnings-related unemployment allowances (unemployment insurance in the U.S. sense), paid by unemployment funds associated with trade unions, and basic means-tested unemployment allowances (unemployment assistance in the German sense), paid by local social insurance offices. Each of these systems pays child supplements for children under age 18.

THE UNDER-3s IN FOCUS

While what is to us of greatest interest in Finland is the day care - home care package, an under-3 "exemplar program", we begin with the money programs. Service, leaves, supports cannot fulfill their functions without an adequate family income base. Prior to its recent major economic slump, and high unemployment, occasioned by the upheavals in its economy following the Soviet Union breakup (for Finland, a protected market under a barter arrangement and which took 20 percent of exports) and the major European recession, Finland has enjoyed an extended period of extraordinary economic growth, high living standards, good wages, low social assistance loads. Child allowances, while moderate in Nordic context, offered important supplements to ensure societal sharing of child rearing costs and the service systems were part of a good standard of living and supported the family life patterns which had evolved.

1. Child Allowances and Tax Concessions

Discussed under the European rubric of "equalization of burdens", child allowances are intended to ease the pressure which comes with the added costs of raising children. Finland's researchers have frequently focused on the costs of a child. Child allowances are tax-free, not means-tested, and increase by a child's ordinal position. There was an under-3 supplement of FIM 107 ($24) per month but it was abolished in 1993 as part of the effort to meet budgetary pressures:

Table FI-1

Child Allowances, Finland, 1992 and 1994

Child's Ordinal Position	Monthly Allowance in FIM			Numbers
	1992	1992$	1994	(1992)
1	366	$ 81.62	570	598,000
2	413	92.10	720	311,000
3	512	114.18	910	88,000
4	645	143.84	1,030	19,000
5 +	842	187.77	1,220	12,000

The 1-child allowance in 1992 added 3.6 percent of a male average production worker's wage to family income and the 2-child allowance added 7.6 percent. [In reporting the "worth" of benefits, our point of departure is a 1992 monthly male average production worker's wage (APWW) of FIM 10,299 and a female average of FIM 7982.] The 1994 allowance increase was an attempt to protect lower income families with children as budgetary problems required the abolition of child-related tax deductions.

Until 1994, Finland also had tax allowances for those who rear children, and their total costs were estimated at about equal to the costs of child allowances. Unlike the situation in other European countries where conservatives tend to favor the tax exemption route while the center-left, left, and unions favor child allowances, Finland's conservatives advocate for child allowances. This is consistent with the long-term preference of agrarian parties, with a large low-income constituency, for universal benefits. Thus, whereas there has been much public debate in recent years about home care versus day care, child allowances are a given. Alestalo and Uusitalo (p. 226) document the growth in benefits between 1962 and the early 1970s.

Finland's family policy was influenced in the 1930s by the concern with the fertility decline and began with some tax concessions for families with children and maternity grants for low income mothers. Allowances were inaugurated in 1943 for large families, again in the pro-natalist mode (abolished in 1974), as were loans for young couples. However, when the present child allowance system was inaugurated in 1948 it was a response to employer's desire to restrain general wage increases (repeating the French history). The Agrarian party urged that all families with children be covered. There was, as indicated, a general decline in the value of these benefits from the mid-1950s to the early 1970s, but the interest revived then, allowances were increased several times, and the supplement for under 3s was added. Alestalo and Uusitalo (p. 213) stress the fertility concerns; in recent years other experts have cited a broader concern with equalization of burdens and the enhancement of child development.

Despite active and visible demographic research and reporting and population policy discussions, pronatalism has apparently not been an important explicit driving force in child and family policy most recently. The social welfare minister of Finland, Tarja Halonen, told the Conference of Family Ministers in 1987: "We have no population policy programme.... The increasing number of the elderly and the probable reduction of the birth rate have brought about concern, however.... When the age group of children diminishes there will be better future possibilities for family policy to shift from quantitative to qualitative needs..."[4]. Nonetheless a system which pays higher allowances to later children is at least implicitly pro-natalist.

2. Prenatal, Maternity and Postnatal Care

Finnish political leaders, experts, and professionals in the field think of their "under-3" package as combining: (a) good medical care and supervision (prevention programs) in the prenatal, maternity, and infant phases; (b) adequate time for parents after childbirth (leaves and job protection); and (c) financial support to permit parents to play their roles and give children a good start; and, then, (d) a variety of at-home or publicly-provided care options to facilitate choice and permit one of several patterns of home and work meshing. Here we begin with the health/medical service supports.

Background

When Finland began its modernization after World War II it concentrated on health care centers and primary schools in rural areas and in poor areas, moving to Helsinki with this development only later. Since Helsinki had the most provision, it still has the most private health care provision now, about 20 percent of the medical care being private. There are some private hospitals. But the universal health service, publicly operated, is by far the major source of care in the country as a whole.

People have the option of getting their medical care privately, paying through insurance, and receiving reimbursement. There is a payroll deduction for this. There is a relatively large deductible, which earned tax credits up to a fixed sum until 1992 (when it was dropped during economic depression). The private system has some advantages, faster service particularly. Everybody joins the public insurance system, practically everybody uses the primary health care system (the local health centers for children). They also can turn to private doctors if they want to and get reimbursement. Twenty percent of the volume of care and 30 percent of the costs are through the private system, and 80 percent of the volume of care and 70 percent of the costs are through the public system. The private system includes hospitals for women and children as well, and it is also partially subsidized publicly. There is also beyond this a true private system in which people simply buy health insurance with no public involvement. There are some people who want to know that they have paid the premium and will not have deductibles.

The local primary health care center is central. Ninety-five percent of people use it for maternity care and childbirth and people use the public hospitals for long term care for children who need it, without any fees.

Finland's top public health nurse, Eeva-Liisa Vakkilainen, our background "briefer", has experience in the provinces as a midwife and public health nurse. She has been working for the central government for twelve years. On top of her nursing and midwife qualifications, she has a master's in public health and special training in public health administration. She is part of a new staff building the health part of the program into a unified social welfare administration. Hers is an "expert office" not an administrative office. The services are delivered by and are the responsibility of municipalities. There are national mandates and money for the services included in the general block grant to the municipalities with reimbursement at various rates, depending on local per capita incomes. Nationally, the office compiles materials, serves as experts, develops special projects. The director general of the department is a pediatrician/ psychiatrist who has previous background in social affairs (social welfare), and there is interest in integration of the two streams, health and social welfare, but little experience yet as to what this means. Motives for creating the unified department in one sense have to do with better integration, but here, too, there is immediate acknowledgement of a search for economy, as well.

The Finnish history goes back to 1751 when there were communal midwives in what was then a unified Sweden/Finland. In 1920 the Mannerheim League for Child Welfare began to train nurses to care for young children. There was a children's clinic as far back as 1904 and a maternity clinic as far back as 1926, both private. The present history is best explained by the situation after World War II. The public health nurse, municipal midwife, and the child health clinic as universal services originated then. In effect, a country that had lost Karelia, had to resettle about an eighth or tenth of its population, owed heavy reparations, moved towards universal coverage program as the most efficient and likely way to get results. Programs that worked, then became popular. It does not occur to anybody now that there is any way to get maternal care than in these universal clinics. In an earlier era there was little separation of maternal and child health components, but in recent years they have tended to be separate, whether or not in separate buildings. Now, among their experiments, is an effort to let a nurse and a doctor take care of a full local population. Our briefer tends to be skeptical about this because there is a level of specialization and expertise needed; will the same public health nurse be expert for child, maternity care, and the elderly? At any rate, she does ascribe the low infant mortality rates to the excellent, universally used, high quality child health clinics.

In contrast to Denmark, the public health nurses do relatively little home visiting here, except in rural areas. They conserve time and actually are very good contact people because there is a tradition of coming to the clinic. They know the value of the home visit for getting to see how people live, and there is some tendency to want to increase home visiting now by hiring public health nurses and doctors for this purpose. The doctors now go out particularly for the treatment of senior citizens.

The exact physical arrangements for these services vary with the municipality. For example, family planning, maternity and post-natal care, child health, mother's classes, dental services, could all be in one building. Nonetheless there does tend to be some segregation of the child health clinics from the clinics serving the others, or there might be one building with different wings. It should be noted that the dental service at the health center is very important and practically all Finnish children come there to get free service until age 17. At that time they can switch to private service or continue at the health service with a modest fee.

Some families nonetheless do use private services; perhaps in some way they think there is better quality in private service. Many seem to go to both public and private for a double check-up on major problems about which they have concern. Official documents contain suggested "schedules" for prenatal visits to the clinic, visits with the newborn, visits in the early years of the child's life - and what should occur on each of the visits. They are oriented both to the doctor and nurse roles. The only indication of routine home visits is the contacts in the first two weeks.

It was stressed that although historically the emphasis was on following norms and procedures from the medical end, there is more and more attempt to go beyond the physical into what might be thought of as family education, support, and cooperation with the social services. Inadequate physical resources, poor care, possible difficulties in dealing with the child can be dealt with directly by the nurse. She has some discretion as to when she refers to the social workers, to the doctor, to the family guidance setup. As much holds as well with reference to child abuse. Given a good basic and comprehensive child health service, here, as elsewhere, there is less likelihood of setting up special detection units for child abuse and less need to refer to social services if the problem can be dealt with in the course of normal medical servicing.

The routine also includes inoculations. Sometimes, depending on the municipality, the doctor and nurse at the child health center are the ones who serve the schools as well. On the other hand, that is not always the case even though there is always a stress on cooperation.

Although at one time the ratio was three or four applicants for every position for nurse training, and the proportions are now far lower, Finland still has a good applicant supply for this very responsible job.

A few special projects underway suggest some of the issues being discussed. One of them, as already noted, would put one professional in charge of a full population, contrasting the results with a situation where there are specialists for children, for the elderly, for maternal care. Another project is experimenting with a three-center arrangement of maternal care, child health, and school health. In any case, the national government offers suggestions, and does not require this level of reorganization of municipalities. At one time there was special health financing, but now it is part of a block grant to the municipal government, as is all other financing. The central office people always worry as to whether their particular approaches and their programs get adequate attention (the current concern now is with parent education, for example). Nonetheless, they are reasonably confident that it will all develop properly since much of this came after a lot of discussion, visibility of new program directions and choices. The various professions involved support the philosophy and the need to implement properly, and the public does as well. If things do not go well they will complain about the way in which their village is deprived. It is believed that there is some decrease of medical care and public health work in the schools. National leadership would like to do more preventive educational work, but it is hard to show results so as to get municipalities to assign appropriate resources. The tendency now is to channel scarce resources to the elderly where they clearly are needed.

At no point in the interview was mention made of poor people, minority people, immigrants, but when an explicit question was asked, the response immediately given was that since this is a free service everybody is in it. When the public health nurse recognizes the need for more supportive attention they pick up situations and do what is required. The important thing is the tradition from generation to generation of a free service that everybody uses. People come to the health centers. For example, groups of mothers come in and drink coffee and talk about shared problems. Long ago it was the matter of a public health nurse talking to a very large group. Now there can be three or four families coming together and talking. The fathers may be present, too. The mother does it of course during leave whether the basic maternity leave or the extended leave; they also come at other times when back at work.

The public health nurses are well trained for this work. They have four and a half years of standard training and some speciality training on top of that. The pay is quite satisfactory, and is dramatically high compared to poor countries. Nonetheless, it does not compete with engineering or other technical fields which have been open to women for some time.

A lot of the education on nutritional matters for children takes place in the school and the school meals represent exemplars as well.

When there are problems which they regard as too complex for them or as requiring specialists, these are referred by the nurses to the guidance personnel or the social workers. There are also outpatient clinics, clinics in the churches, etc. Public health nurses are encouraged to develop mental health understanding and not to refer too quickly. They know the family, know the situation and are expected to try to help first.

Operations

Finland has an exemplary operations network of health centers which offer both preventive services and medical treatment as needed. We describe one center in the City of Kirkkonummi in the "On the Ground" section. A center, paid for out of tax funds, integrates the primary care doctor, a family planning program, prenatal care, and a well-baby program for supervisors of infants and toddlers in particular. The hospital and medical care service is co-located but separate from the preventive service. It is universal and free. There is no difficulty about involving mothers in pre-natal care: "it is the usual thing to do." A pregnant woman will be seen as many as sixteen to eighteen times by a mid-wife/ public health nurse and doctors and upon childbirth receive a rich maternity packet or cash equivalent, if preferred. The packet, which varies slightly from year to year, contains a good supply of infant clothing, bedding, towels, sheets, diapers, and toilet articles, all packed in a box which can be used for the infant's sleeping. It is worth more than the cash alternative of about $165 and is selected by practically all mothers with first children. The others save the contents for subsequent children. The attractiveness of the packet is acknowledged and described with pride, yet few people believe that it actually explains the widespread participation in pre-natal care.

After her return from the hospital following childbirth, the mother is visited by the midwife, examined, and then a transfer is made to the local public health nurse. All mothers and their newborns are visited two or three times. If there are problems requiring attention (alcoholism, a handicap, some other concern) there will be more home visits. Most children are seen by the nurse (eleven times) and the doctor (three times) in the first year at the child health center. The inoculation program begins at age 3 months. Careful records are kept. For routine check ups children then see the nurse at the center annually and the doctor every two years. If the child is ill, it is brought to see the doctor (not necessarily the will-baby clinic doctor) in the other building. Should the mother be ill, a home health visitor may be sent. There is a "big" check up of the child at age 5 or 5 1/2 before compulsory school entry at 7, and the intervening time is used to cope with school readiness and deal with whatever medical measures are needed.

The public health nurse has a close cooperative relationship with the social work services and plays a variety of advice and educational roles with parents on a one-to-one basis and in groups (see below). She is well-trained in a specialized 4 1/2 year program after secondary school. Many have both midwife and nursing experience and some add graduate training in public health. The services are mandated in connection with the national block financial grants to municipalities so there in fact are different patterns for the relationships among the child health and maternal parts of the preventive and treatment services. There has been a tendency in recent years to place the child services in different buildings than those housing family planning, maternity and post-natal care or dental services. An alternative current direction is to decrease specialization and ask one doctor to assume responsibility for a total population. Although there is some overall tendency to limit home visiting, the child health nurses are clearly oriented to issues well beyond physical health and attempt to use contacts, whether in the home or in the well-baby center, to pursue such issues. On the other hand, social work and mental health services, while appreciated and available, are relatively small-scale.

3. Maternity, Paternity and Parental Leave

Mothers are eligible for maternity and parental benefits for a period of forty-six weeks if the have lived in Finland for six months before expected confinement (twelve days were added late in 1990). The "maternity" part of the benefit covers up to five weeks (30 work days) before the expected time of confinement and 75 workdays after the child's birth. Then there are 158 workdays for a parental leave to a total of 263 (30 + 75 + 158); the latter may also be claimed by a father who is a child's primary caretaker. An additional 6-12 days are available to a father immediately after childbirth while the mother is on leave. (The computation is on the basis of six days to the week). One-third of all fathers use the 6-12 day provision to help with the new child or older children.

Reflecting both Finland's important rural sector and the political power of its Agrarian party, provision also has been developed to allow farm mothers to use the leave, by supplying substitute help financed by local government. In its most recent expansion, provided for in the 1990 agricultural collective agreement, this substitute help may cover the entire maternity-parental period, if the mother elects it all.

The cash benefits paid during these leaves are earnings-related and are equal to about 80 percent of earnings, but there also is a low benefit for mothers or fathers without labor force attachment (as there is in Sweden), equal to about 15 percent of an average wage. There is no ceiling for coverage of high earners, but the replacement rate declines (corrected by a modest supplement). Some collective bargaining agreements provide for full salary replacement by the employer for the first six to twelve weeks of leave. (In such cases, the employer collects the government benefit). These benefits are taxable.

The leave is available only to one parent at a time and the mother has what in effect is the right to first refusal. If she takes only part of the leave and returns to work, she collects a minimum benefit to the end of the eligibility period. Only 6 percent of mothers do this (for 3 percent of all parental leave days). Fathers use only 2 percent of parental leave days. The basic maternity-parental leaves, like all social insurance, are financed out of employer - employee - and government contributions. The extended parental leaves (158 days) are fully financed by government.

As will be indicated below with respect to "home care allowances", the program reflects a compromise between Social Democrat and Agrarian parties. The former have stressed the proportion of the wage replaced and the latter raising the level of the minimal allowance for those not in the labor force. Eventually, both parties achieved their objectives.

4. Child Care or Home Care Allowance

Unique in Finland is the package of child rearing support options available from the expiration of the forty-six week post-childbirth leaves and benefits until the child reaches age 3. This benefit, which is government financed, introduces the possibility of at-home parental care with job protection and some financial support until a child is 3 - but at-home care is only one of three options. For low earners, the home care allowance is not very different from, indeed slightly exceeds, the unemployment insurance benefit. That benefit covers 500 work days. Given the relationship between earnings level and the unemployment benefit, however, higher earners receive considerably more from that benefit (if eligible), than from the home care grant.

As mentioned earlier, the main family policy debate in Finland is between advocates of financially-aided home care of young children and those favoring more adequate provisions of child care programs. The mid-1980s "compromise", to offer all options, followed a long period of debate and the recognition (in the period before the U.S.S.R. breakup) that constitutional provisions regarding the budget required consensus. Thus, the right and center, the governing coalition, favoring allowances for at-home care, and the Social Democrats, urging expansion of the child care supply, developed the program offering both options for parents of children under age 3.[5] Finland emerged as the only country in Europe with a statutory guarantee of child care space for the under-3s effective in 1990 (a comparable guarantee for the 3-6s is not effective until 1995).* Parents have two other options, however, payment for their own at-home care or a sum to permit them to make their own care arrangements.

The home care cash benefit is most attractive to relatively low earners, or to those two-earner families whose total income is such that a decrease in one income is readily tolerated. The basic home care allowance is similar to the maternity - paternity - parental allowance for a person not in the work force, about 15 percent of an average wage. Another 20 percent of the basic amount is payable as a sibling benefit, if there are two or more children. Low income families (low-income is about 35 percent of an average wage) get a maximum additional sum, so that the basic amount, sibling amount, plus the addition bring the benefit to about 30 percent of the average wage. The amount of the addition varies with income, being available to those with no income at all but also covering all those at about the median female wage or below, on a sliding scale. The basic amount is not payable if there is a new maternity - paternity - parental benefit, but the sibling addition and the income-related addition are. As of 1990, over 80 percent of those eligible used some of the home care benefit, both the leave and the payments, to extend the maternity - paternity - parental leave period for an average of fourteen months beyond the forty-four weeks. By the end of the third year, only 20 percent of families were using the benefit. Major variables differentiating the users and the non-users are the wage and education of the mothers. As might be predicted, those earning below the average female wage are likely to use most or all of the entitlement. Those who are well-educated are better paid and likely in any case not to want the longest career interruptions.

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* This paragraph covers the pre-1993 picture which prevailed during our visits. See below.

Compelled to meet the higher costs of guaranteed child care places, some of Finland's municipalities supplement the home care allowance significantly as well. Helsinki makes a particular effort in this regard.

Currently, given the child care guarantee and an allowance for home care at its most generous level, few families use the third option of care by domestic servants, relatives, or informal care givers. At the beginning of 1990, of 195,000 children under age 3, some 29.2 percent were in parental care under the maternity - paternity - parental benefit scheme, 43.4 percent were in care under the subsequent home care allowance benefit, and 27.4 percent were in day care away from home. (Data also are available for all children under school age (7) for January, 1992: 12.5 percent cared for at home under the maternity - paternity - parental benefit, 29.5 percent cared for at home under the home care allowance benefit, over 50 percent in day care, and the remainder without governmental support.)

It might be noted the unlike the situation in Germany (Erziehungsgeld), in Finland the at-home role under the extended benefit is made feasible for the low income single mother, when packaged with the other available benefits. Many single mothers, higher earners, do not use the option, because it would mean a decrease in their living standards. Observers call for a program to facilitate labor market reentry after a two to three year withdrawal. Useful to lone parents is the shorter work week option which provides 25 percent of the home care allowance (see below).

In 1993, the incentives for at-home care was increased by doubling the grant for at-home care of one's own child, and the income testing for the addition was dropped. It is not yet known how this affects take-up. A further stay-at-home incentive was added in 1991 when it was ruled that pension credit accrues during the home care leave as well as during the maternity - paternity - parental leave. The shift in the political environment will have ended the symmetry of the options.

5. A Shorter Work Day

Like Sweden, Finland offers parents of very young children a shorter work day/week option. But unlike Sweden, take-up is barely visible. Moreover, most Finnish women work full-time whereas the frequent (half) Swedish pattern for mothers is part-time work.

Parents have the option of this benefit until a child is age 7, when a child first enters elementary school. Parents may either reduce their work day by two hours or remain at home one full day each week. Until the child is 3, there is very modest partial financial compensation, 25 percent of the home care allowance. This component was added in 1990 (before that it did not apply to the years when the child was 4-6), but thus far not many families utilize the benefit. In 1992 only 1,959 families used the benefit at any one time. One available study showed (as in Sweden) higher use among public than among private industry employees. Almost all the users were women (6 percent of those eligible) and they tended to be either completely unskilled or among the most educated.

6. Child Care Programs

As already indicated, child care is a major under-3 option, is now covered by a guarantee for the under 3s, and in 1990 served over 27 percent of the cohort, either in centers or municipally supervised family day care. An overview of several centers in operation is presented in the final section, but here we offer a system overview and note that with child care as an entitlement parents now have the right to turn to the courts where there are problems with the sufficiency and qualitative adequacy of the supply. It remains to be seen what the opportunity will yield.

First, it should be noted, some of the under-3s, are in infant-toddler care; these would be 1 and 2 year-olds, since the infants are practically all (99 percent) at home cared for by a parent on maternity - paternity - parental leave. Others of the under-3s are in age-integrated day care ("sibling groups"), which covers children from age 1 up to age 7, the time of school entry. Others are in municipally supervised family day care.

A small sub-group participate in other types of child care programs which are part of the system; centers for children with special needs; "open", drop-in day care centers for children with at-home mothers or baby sitters and geared towards child rearing education; mobile centers for rural areas intended mostly to provide a preschool experience to the 5s and 6s; and a few extended hour or 24-hour centers, responsive to irregular work hours.

In 1990, only 1 percent of the under 1s were in family day care or a center. But of 122,000 1s and 2s, 27 percent were in family day care, 21 percent in center care and the remainder were either in parental care (30 percent) on the basis of the maternity - paternity - parental leave or the home care leave, or (22 percent) in relative care. Only Denmark in our sample exceeds this out-of-home coverage.

Finland's child care is municipal and publicly subsidized. It is largely publicly-operated although a small sub-set of centers is privately operated, meeting public standards. Of those in care (up to school age), two-thirds attend full-time and one-third part time. A Day Care Act initially passed in 1973, specifies limits on group size and child-to-staff ratios:

- center care, children under age 3, full-time: 12 children and 3/4 staff

- center care, children under age 3, part-time: 12 children and 2/3 staff
- center care, age integrated, ages 1-6, : 15 children and 3/4 staff
- center care, children ages 3-6, full-time: 20 children and 3/4 staff
- center care, children ages 3-6, part-time: 25 children and 2/3 staff
- family day care, maximum of 4 children, one adult
- three-family day care, 2-4 families, one provider
- group family day care, 2-3 caregivers and up to 12 children

There is said to be adequate capacity in centers and family day care now for the 1-3s, but not for the 3-6s, who may be on waiting lists and in informal or not-preferred other facilities.

The 1992 recession and unemployment created an anomoly for the 3-6s, excess capacity in some locales (11,500 places) and shortages in others (5,500 places) as reported in a study for the National Research and Development Center for Welfare and Health.

Within the formal facilities, each group has at least one preschool teacher who has completed a three-year course in a special institute, following basic secondary education. Some of the programs are in university-based teacher training units. The other staff members would be considered aides in the U.S. sense, often called "trained day care nurses" in Finland. Their specialized training extends for two and a half years. The profession is considered low-pay and low-status and has had great difficulty recruiting or holding males, despite a period in which some jobs were reserved for them. Family day care providers are required to complete a 250 hour course as minimum training; this course work is taken part-time. They receive continuous guidance, advice, and support from supervisors who visit the homes and often conduct extra training sessions. Each supervisor is responsible for thirty child minders (compare the superior Danish ratios). Most of the supervisors have been preschool supervisors or are otherwise qualified by university training. In general the family day care providers are older than the center staff.

In the Nordic pattern, Finland spends approximately as much for day care centers plus family day are as for the combination of child allowances and tax relief for children.[6] This is a combined income transfer and service strategy. (Child health service costs, part of the larger, separate health budget, do not figure in this generalization.) Income transfers are paid for out of national general revenue. Child care is municipal but municipalities are reimbursed for their costs on a scale related to their relative economic well being, in the range of one-third to two-thirds of both capital and operating costs. With the best economy in Finland, Helsinki, at 29 percent, has the lowest level of national reimbursement. Municipalities, in turn, set parental fees which are based on income and family size (see "On the Ground"). On average, parental fees meet 11 percent of costs (1991) and are identical for family day care and center care. The poorest families pay nothing, but a one-adult family earning slightly over half the average wage would pay almost 5 percent of earnings.

An effort has been made in Helsinki, for example, to ensure facilities in each neighborhood by construction, use of prefabricated buildings, or renovation of apartments. Sometimes, there is a cooperative construction project involving some of the following: library, school, day care, health station, social security office, or post office. There is preference in Helsinki currently for small facilities, two groups of sixteen children each, or thirty-two children of ages 3-6.

Certain national specifications must be met to justify the subsidy: "full-time" is to be a maximum of eight to ten hours, "part-time" is four to five hours; group staffing norms (see above) are specified, as are training expectations. Until a recent law change, with few exceptions, centers were limited to 100 children.[7] This is no longer in effect.

The intellectual orientation and policy framework of this child care system have recently been discussed in a Finnish volume describing how young children are served in a number of countries[8] and in a hundredth anniversary compilation by the child welfare union and Association of Nursery Teachers.[9] Finland, the first Nordic country to offer day care services, began in 1888, as a Froebel-oriented kindergarten. Nowhere else among the Nordic countries has Froebel been so influential. The goals go well beyond custodial care, stressing as well (in Froebel's words) "incentives that match the child's age and being, strengthens their bodies, trains their senses, keeps active their awakening spirit as well as acquaints them with nature and society".[10] In a more recent statement the professionals state that the "aim of day care is to support parents in their upbringing tasks and, together with the home, advance the development of a child's well-balanced personality".[11]

In a more analytic, historical overview Ojala conceptualizes for Finland a preschool stage (ages 0-6) before the "basic stage" of education (ages 7-10).[12] The preschool stage is composed of home care, day care and a voluntary preschool year for 6 year olds. He, too, notes the borrowing of the Froebel kindergarten idea from Germany, as a component of the Enlightenment and an effort to raise the general level of education. To the end of the nineteenth century educational authorities administered kindergarten despite an earlier shift to a social welfare emphasis. Kindergartens were serving children of poor families, in an effort to keep them off the streets. Educational goals had become secondary. The 1918 Civil War created social conditions which strengthened this orientation.

Kindergartens grew very slowly in Finland before World War II but growth was rapid thereafter. Until the 1973 legislation creating the present framework, only children ages 3-7 were enrolled.

A parallel system of nursery schools developed from late in the nineteenth century but, unlike the kindergartens, without governmental aid. Some enrolled only infants and toddlers, the others covered children through age 6.

The rapid shift from an agrarian to an industrial urban society, with large numbers of employed mothers, accelerated discussions of child care, and the 1973 legislation created the present framework. According to Ojala many voiced a preference for home care from the beginning. The law charged municipalities with providing facilities to the degree and in the form that needs required. Prior to the more recent target of coverage by entitlement (unless parents choose home care), priorities were set according to social and educational needs. The formal home care supports were to come in the 1980s.

Ojala describes an eclectic program philosophy which supports the "educational function of the home" and works with the home to further the "balanced development of the child's personality". There is stress on ensuring "safe and warm human relations" as well as activities supporting rounded development and offering a "growth environment".[13] Clearly, this is not merely custodial care. The elaboration of objectives is consistent with what general child development training institutions stress almost everywhere in advanced industrial societies. National standards as to physical space indoors and outdoors, hours of operation, group size, staffing ratios and qualifications, and suggested daily routine are meant to protect children and advance these objectives whether in publicly-operated facilities (the majority) or in private programs. There is a balance between "guided activities or a teaching period" for the entire group or small groups (after breakfast, the length varied by age and, again, after the rest period) and free-play indoors and out. There is a preference for integrating children requiring special care and training in the "normal" groups.

Family day care orientations and requirements are also specified, stressing a home-like model. Ojala emphasizes the special value of family day care for children under age 3, although clearly preferring home care for that age group. On the other hand he reports high levels of parent satisfaction with both types of care for all age groups. He reports that, as compared with home care children, day care "neither hinders nor substantially furthers" the child's development. Except that he also reports that under-3s "have in some cases had difficulties in adapting to day care" and that in general center children are more disruptive when they enter school.[14]

Nationally, today, day care programs are in the province of health/welfare authorities but the required preschool training is within the higher education system. As decentralization to municipalities for operations is accelerated, it may be that diversity will increase - or that new service patterns will emerge. Or that standards will suffer with decreased central inspection. In any case, facility expansion and curriculum are on the active agenda. Ojala predicts a major family day care decline as it is replaced by home care - while other parents continue to prefer day care centers.[15]

CONTEXT

1. Demography and Labor Force Participation

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Finland, with a 1990 population of 5.0 million is, with Denmark, (5.1 million in 1990) one of the study's small countries, in contrast to France, Italy, and the United Kingdom, approaching 60 million, and Germany, now about 80 million following unification. With a total 1990 fertility rate of 1.7, below replacement, Finland is similar to France, United Kingdom, and Norway, behind Sweden (2.0), but leading Italy, Germany and (slightly) Denmark. And, like France, Finland has a tradition of considerable (and expert) demographic research as well as some alertness to the fertility issue. As indicated earlier, while there is some degree of controversy among observers and scholars as to the exact salience of pronatalist objectives in most recent enactments of family supportive measures, including home care grants, there is little debate as to the historic role of fertility concerns in generating family allowances, tax concessions and other policies - even though there obviously have been other motives as well since World War II.

Although somewhat later, because of its later industrialization, Finland has shared the demographic transitions of most advanced industrial societies and, with its Nordic neighbors, is among the leaders in some trends. While fertility has declined, so that there are fewer children per family, motherhood is more general than ever before. Parents are older when they have their first (sometimes second) children; relatively few have three, four, or five children, so that many children have no siblings or one. However, only one child in seven has no siblings at all. Despite a divorce rate above the

Nordic average, higher than Sweden and Norway, but similar to Denmark (2.93 per 1,000 population, 1989), practically all of Finland's newborns live with both parents. Of children below the compulsory school age of 7, some 93 percent were living with two parents in the early 1990s. And, although many young children are not in parental care during the day and experience what one group of scholars calls "dual socialization", research reports affirm and observers insist that the family remains a sanctuary of intimacy.[16]

With other advanced industrial societies that have low birth rates and have improved longevity, Finland is an aging society. Its over-65 population constituted 6.6 percent of the total in 1900, 7.8 percent in 1940, and 14.5 percent in 1980. The aging pressure has had its impacts on pension and health expenditures. From a slightly different perspective we might note that in 1960 there were 328,000 over-65s in Finland and 1,340,000 under 15s. In 1980 the over 65s totaled 572,000 but the under 15s were only 965,000, a low number. In the years 1981-85 Finland averaged 64,868 live births annually; the 1989 birth cohort totaled 63,388, but for 1990, 1991, 1992 the totals were, respectively, 65,547, 65,170, and 66,700. The situation has stabilized since the early 1970s where Finland had its lowest fertility and lowest birth rates since World War II, lagging behind all Nordic countries. If total birth cohorts decline somewhat in coming years, it will be because of the reduction in the size of the population in the child bearing ages. As of 1991, 19.2 percent of the population was under age 15 (the comparable U.S.

percentage was 21.7) and 13.6 percent over 65. The under-3s, here in focus, numbered 194,000 in 1991.[17]

OECD data report a 72.9 percent female labor force participation rate for Finland in 1990, exceeded in the west only in Denmark (78.4 percent) and Sweden (81.1). Women constitute almost half the labor force. Denmark and Sweden have far more part-time female employment and Finland, at 10.2 percent, has very little. Considering people at home on maternity or parental leave as in employment (but not those on home care leave), Finland's statistics show 85 percent of mothers of minors in the labor force, 80 percent of them full time. In recent years, prior to Finland's current economic set-backs, Finland had extraordinarily low male and female unemployment rates, by international standards. It is one of the few "western" European industrialized countries not to rely on guest workers or immigration.

Although male and female workers have similar educational levels, training and jobs are gender-segregated and, on average, women earn 25 percent less than men. Lone mothers have a higher employment rate than other mothers. Their earnings, aided by income transfers and tax benefits, raise their disposable incomes almost to the level of other families.[18]

Single parenthood increased during the 1970s and has since stabilized at about 15 percent of all families. Half of lone parents are divorced and another 15 percent separated. Of the 19 percent of all children born out of wedlock in 1987 all but 3 percent, according to a 1990 study, were with parents who were married or cohabiting. Pre-marital cohabitation has become very common, almost normative, but most such couples marry at the time of childbirth. For purposes of taxation and receipt of social benefits, cohabitation is treated as is marriage; this is also true with respect to rights and obligations vis--vis children. Contraception is effective and abortion available. Children who are born are almost always described as "wanted". Some experts report a growing infertility problem, ascribed largely to the postponement of first births (average age 28.6 in 1990) because of extended education and housing shortages.[19]

In a recent review of Finland's lone-parent situation, Haataja reports a total of 70,000 - 100,000 lone parent families (10 - 15 percent of families with children), depending on definition (children's age, cohabitation or no). Most (90 percent) of lone parents are female.[20]

Immigrants and refugees are a new experience for Finland - even more so than in the other Nordic countries. One cannot cite Finland's programs and benefits as accommodating to or serving diverse populations. There is virtually no relevant experience.

2. Expenditures

In an extensive historical overview, Alestalo and Uusitalo note that the Finnish state was exceptionally important in the development of the modern Finnish economy, both creating the infrastructure and directly owning a high proportion of industry, as compared with OECD countries. This growth was especially visible in the late 1940s, the 1960s, and the latter half of the

1970s. Social expenditures followed a similar pattern, in fact grew more rapidly than total public expenditures.[21]

Within public expenditures, public consumption and transfers to households grew while investments diminished proportionately after the mid-1960s. Early in the 1950s, income maintenance was a modest item while social services were quite important, but as Finland's welfare state was shaped, health expenditures exploded and stabilized at over 20 percent of social expenditures by the 1970s. Income maintenance achieved its more characteristic dominance with the pension explosion from the 1960s through the 1980s. Child allowances, nearly half of all income maintenance in the early 1950s, had declined to one-tenth by the mid-1970s.[22]

We have referred earlier to the concern for declining fertility which affected the development of tax concessions, maternity grants, child allowances and loans for families in the 1930s and 1940s. However, by the 1950s, the decisions affecting health and pensions led to the steady decline until 1973 in the proportion of social expenditures going to families and children.[23] Then, the expansion of child care, the special allowances for under-3s, a successions of increases in general child allowances, expanded maternity allowances, as well as growth in the value of benefits, all signaled new growth in child and family expenditures from the early 1970s, despite a declining child population.[24] In a mid-1980s assessment by two Finnish experts, it is noted that family transfers meet part of the economic costs of rearing children, but not nearly enough to equalize the situation for families with two or more children, who are overrepresented in the lowest per capita income quintile: "Surprisingly [however] single-parent families have an only slightly lower level of per capita income than two-parent families when the number of children is kept constant".[25] As noted earlier, Haataja reports similar trends for more recent years.[26] If one also considered tax concessions, the overall Alestalo/ Uusitalo conclusion is even more strongly justified: "redistribution does equalize the economic costs incurred by children, but does not reduce the major variations in living standards between types of families a great deal".[27]

Our own overview of the cross-national comparative pattern for 1960-1985, again not covering tax expenditures or (in most countries) services, local government (for the most part), and the private sector, shows Finland as above the OECD average for government social expenditures as a percent of GDP for 1960, but not for 1975, 1980, or 1985.[28] It lagged in social expenditure growth rates, but until the mid-1980s was above OECD norms for social expenditures as a percent of government expenditures. In purchasing power parity dollars and at fixed 1980 prices, Finland's family transfers per child were well below OECD averages throughout, and its family benefit share in GDP expenditures also were somewhat below average after the 1960s. In the current period of general ascendancy of health and pension expenditures, Finland's family benefit expenditures have come to resemble the OECD pattern in a variety of measures.

Finland is close to the Scandinavian norm for all social expenditures. And like Denmark and Norway, it has a level of service expenditures far higher than the cost of cash benefits, something not common elsewhere in OECD. The current child and family expenditure picture is noted in the following table:

Table FI-2
Social Expenditures, Children and Families, 1989 (FIM Billions)

CATEGORY	AMOUNT
Income transfers	
child allowance	4.8
tax relief for children	3.5
housing subsidies	1.3
child-maintenance allowance	0.3
survivors' pensions	5.5
child care allowance	0.4
maternity, paternity, parent's benefits	3.7
home care allowance	2.7
SUBTOTAL	22.2
Services	
day care centers	4.4
family day care	2.6
school meals	1.3
home help	0.4
child welfare	1.1
other	0.2
SUBTOTAL	10.0
TOTAL	32.2

Source: Kamerman and Kahn, 1991, Child Care, Parental Leave, and the Under 3s, p. 168, as updated in Sosiaaliturua Suomessa, 1991 (Helsinki: Ministry of Social Affairs and Health).

In 1989, 1 FIM = $ .233 or, in purchasing power parities, $ .189.

We already have commented on the "balance" of child allowances plus tax reliefs with day care and family day care expenditures (see Table DK-4). The combination of maternity/ paternity/ parental benefit costs plus home care allowances are a third, almost co-equal, cluster. Of some interest, too, is the finding in a recently completed study to the effect that because of the increased total consumption costs as a child grows, government cash transfers, tax deductions, and free services decline as a portion of total consumption costs.[29] Thus at age 1 1/2 - 36 percent of costs are covered by parents, at age 7 - 64 percent, at age 12 - 70 percent, and at age 13, 84 percent. The societal sharing of burdens is thus greatest for the under 3s.

3. The Political Environment

To review briefly what has already been noted in context: all Finnish parties accept the notion of a welfare state and its Nordic commitments to the philosophy of a "people's home" and "equalization of burdens" (and the tendency to tax universal benefits more than in most regions). The center-right coalition in Finland includes an agrarian party with strong representation of small-holders, so that direct benefits like child allowances are considered important (unlike the preference of the right-of-center for tax concessions elsewhere). There is, too, a major socialist-social democratic bloc, more strongly identified with the needs of working women, while the right-center prefers and tries to provide for the one-earner family.

The particular politics of the post-World War II era, the time when social policy initiatives exploded in Finland, were played out in the shadow of the U.S.S.R. The constitution required a 2/3 vote for the budget, thus enforcing coalition government. The present, post-U.S.S.R., 1991 conservative and centrist government is the first in 25 years without Social Democrats in the cabinet (but a Social Democrat became president in 1993). Most of the child and family policy measures in place reflect the coalition practice of settling differences by satisfying the high priorities of both sides. Thus, as observed, family policy has made the at-home option viable for parents of young children - but also has offered out-of-home care guarantees. The debate about infant and toddler care has been between center care and family day care, while those who prefer the at home option may select it. Currently, the center-right coalition has sought to curtail some costs at a time of fiscal stringency, without in any way undermining basic benefits and services. There is some tendency to re-balance the incentives in favor of at-home care.

Not to be minimized as a political factor is the extraordinarily high, mostly full-time, female labor force participation in a country which industrialized and modernized with unusual speed and did not have the option of guest workers. Even female farm workers have joined the pressure for adequate provision, having relatively recently won the right to substitutes so that they may claim maternity leaves.

The vigorous economic growth of the Finnish economy in the 1980s made the most recent expansions of family and child policy possible, and observers continue to wonder where recent declines in economic growth and conversion to "market thinking" will make their impact. Some of the decisions will depend on the municipalities, as continued decentralization and national support via block grants, and decreased national capacity to inspect, create the risk that what has been a universal and uniform development will become more uneven. It is not clear whether municipal social benefit cut-backs during the 1993-1994 unemployment and economic crisis will continue after economic recovery.

ON THE GROUND - CHILD CARE

It will be recalled that in 1990 over 27 percent of the under-3s and 50 percent of the 3-6s were in day care arrangements out of the home; the remainder were in care under either the maternity - paternity - parental leave schemes or with a home care allowance. However, if one leaves out under-1s, who are all at home, 27 percent of the 1s and 2s are in family day care and 21 percent in center care. There is now a statutory guarantee of child care space for the under 3s and there will be a similar guarantee for the pre-schoolers in 1995.

The under-3s may be found in:

- center care for under-3s
- age-integrated center care for the 1-6s
- regular family day care (a maximum of 4 children)
- three-family day care (sharing 1 provider)
- group family day care (2-3 caregivers and up to 12 children)

We have previously listed the national staffing norms and group size norms for the centers. Each center has at least one professionally qualified preschool teacher and two assistants ("day care nurses").

There are some kindergartens which admit only preschoolers over age 3. There also are playground centers, to which parents or caretakers may bring children on an informal basis, as well as "open day care centers" - which might be interpreted as possibly an early stage of Milan's "time for the family" program.

Most center places (73 percent in 1992) and family day care (86 percent in 1992) are used for full-time care. The auspice for most of this is municipal.

We conducted our observations in two locations: Espoo - a new town picture book residential area - and an old section in Helsinki. Clearly, Finnish center child care is solid and often attractive.

The two sites offered sone contrasts, since Tapiola was a model "new town" created in the early 1960's and visited by planners and architects from all over the world. Helsinki of course is an old city. However, Tapiola has long since ceased to be an isolated garden city and is now one of four areas incorporated in Espoo, the second-largest city in Finland, with a population of some 175,000. The coastline of this city is 58 kilometers long and its archipelago has 163 islands and 95 lakes, all within urban boundaries and more than in most European countries. In short, this is a beautiful area, everything still seems very new and clean, and it has developed a high technology center. Tapiola itself is only one of five hubs in this area, the second being the Otaniemi University campus (where we made a center visit) and a congress center. In some ways, as suggested, it is a picturebook setting, and the children and adults seem to fit in very well. Everything is well designed, clean, beautiful, relaxed, relatively homogeneous and there simply were no sour notes: no conflicts among the children, no harsh treatment of children or strong controls by the adults and, although we were visiting programs for the 0 to 3s, not a child crying until late in the visit when there actually was one who seemed to be in distress and was being dealt with by one of the "teachers." On the other hand, the children were engaged, heavily involved in interaction with one another and clearly happy.

The Helsinki setting visited, by contrast, is the oldest facility of its kind in Finland, does not have the advantages of new and expensive quarters and has a range of children, some reflecting the family and urban problems of today. The environment was very different, yet the children were obviously happy, the staff related to them well, if somewhat more actively than in Tapiola. Tapiola would make a fine documentary and its physical setting could be copied profitably by many places. Helsinki reminds one of decent child care in many places; it is not an exemplar. To conserve space our observation report for Helsinki is not reproduced here.

1. A Tapiola Child Care Center

The Tapiola center is known as Jousenkaari and its address is Jousenjanne 1. This is the name of a street, but all the names in this area derive from various forest terminology. In this case, "the string in a bow". We visited in June, 1992. We spent several hours with the "director", HM, an attractive woman in her late 40's who has had experience as a child care worker, a supervisor and now as a director. She does not regard herself as in a hierarchical relationship to the "teachers and nurses" (the terms used), nor are they in a hierarchical relationship to one another. They are colleagues and peers with different areas of responsibility. She had reached the point where after twenty years of experience and when her own children were in their 20's, she decided that she should not be taking care of little children any longer and found this other kind of work very interesting. She took over a new center when it was built several years ago, had the task with the "inspector" in the municipal office of furnishing it, within guidelines, budgetary restrictions, and some directives as to where to buy the large capital items. Nonetheless, she has a sense of having created the physical setting and a marvelous physical setting it is.

The teacher/nurses are equals despite their different training. Their activities are similar as well, except that in the planning as a team the teachers have a different contribution and perhaps more responsibility. In effect, teachers have responsibility, but not supervision, and are paid a bit more. The leader (director) comes out of this, is called "supervisor," and is also paid about FIM 500 more, but this is not regarded as enough for additional responsibility. Again it's a matter of a job choice. In small centers the leader also plays the role of the teacher with one group. In the large center that was visited first, the leader was devoted to the administrative tasks because of the many requirements of a large program.

The building was created by architects, and we were told that there is nothing special about it. Nonetheless it had the Finnish sense of design, lovely color variations and contrast in the different rooms, tables, chairs, equipment beautifully designed and excellent appearing, and it was all clean and well cared for. HM's feeling is--and one could validate it--that children, adults caring for them, and administration all do better in a beautiful, well-arranged setting. Each room had the individuality of the group and of leadership, and there were wall hangings and other things prepared by staff as well.

This setting has five all-day groups with seventy-eight children. Most of the twenty centers in Tapiola also have half-day groups for four to five hours and some after-school groups. This is the only one that is limited to all-day groups per se. Three of the groups are for the under-3s and two of the groups are for the 3-6s. Each group is integrated within its range, i.e. the younger groups have children as young as 9 months old, going up to age 3, and the others are in the 3-6 range. Since they were just reaching the end of the school year children were pushing the upper limits and a few of the 6s were now just about 7 and ready to enter school when the semester begins in August. There are twenty-four adults caring for and working with these seventy-eight children.

Each of the under-3 groups has twelve children, three professional staff and one helper. The professional staff consist of one person who is called a "teacher" whose three-year education, post-secondary school, sounds very much like what we would call early-childhood education even though it is in a technical school. The two others are called "nurses" but we would think of them more as practical nurses specializing in children, qualified to work in hospitals but not in nursing specialties. They have a two-year education in a specialized school for this day-care work; earlier the older ones had a one to two-year education. As indicated, the teachers are not regarded as the supervisors of the nurses and they work as colleagues. The helpers may assist with the group but they have various other tasks as well, such as laundering, cleaning up, etc.

Finnish day care is now 100 years old and it derived out of the German/Swiss kindergarten movement late in the 19th century. (Indeed, when we visited the center in Helsinki there were pictures of the two Finnish pioneers.) HM found it difficult to conceptualize a theory of child development related to the setting when a direct question was posed. Then, throughout the day, she arrived at and presented various formulations, having obviously been troubled and embarrassed by this situation. One would have no question at all that she had an attitude and a philosophy about the work and that it was a pervasive one, whether or not that is common for all of Finland or something that she has developed for herself. She defines it as the former. Toward the end of the visit, the director having thought about it somewhat said that the emphasis is on creating a comfortable atmosphere, security which is like home. Moreover, staff concentrate on building up a good relationship with the child's family, an open and trusting relationship. The parents need not worry about their children and staff want them to be reassured.

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The children in this setting come from what seem like upper working class and middle class families. There are no real foreign children here, even though inevitably there are a few ethnic mixes in the marriages. They have not been "welcoming" immigrants here yet but the staff talked about the necessity of doing that. Most of the foreigners are in the student city near the university.

We were joined quite early for the first half day by HL, the supervisor of the municipal family day care, described subsequently. She also has a long experience in centers and has served as liaison and supervisor for them. She made no attempt to state a coherent philosophy, leaving the core of the interview for her colleague. They did say that their "Bible" was a 10-year-old report of a national committee but what they quoted was on a quite general level: the child care center program is aimed at "physical" education, "social" education, "emotional" education and "ethical" education, as well as "intellectual" and "aesthetic" education. In short, they have broad aims, certainly do not limit themselves to caretaking or to formal education. A great deal is made of insuring a sense of security to children and assuring their parents that they can be secure with the children here. One does not get a sense of didactic teaching. The children are read to, of course, and they play music and sports with their leaders. They are learning social skills from one another and from the adults who resolve issues. Since the younger groups have the 1-3s and the older the 3-5s, they also learn from the somewhat older children. Elsewhere in Finland, such as the facilities visited in Helsinki, there are also sibling groups covering the ages 1-6. One sees here of course all of the activities characteristic of centers, e.g. dressing up, acting, playing together, eating together, taking turns at serving during the eating and learning to handle such routines as brushing teeth, etc. Each child is individualized at every stage. The child is given a symbol such as an apple, a cat, a boat. The symbol appears everywhere, where the child's boots are, where his or her raincoat is, in the bathroom where there is a cup and toothbrush, on the potty which is individualized, in the cubby where clean diapers are kept in each child's supply, on the bulletin board where ages are shown in some of the rooms.

The observer arrived at the Jousenkaari center at 8:30 a.m. and did not leave until close to noon, so that there was plenty of time both to observe the environment and also to become aware of the setting. This very large physical facility for seventy-six children, for example, has several entrances: one for two of the under-3 groups, another for the third group, still another entrance for the 3-6s. The entrances are labeled by age. More important, however, is the way in which each group has its cluster of rooms, in a sense a small apartment. We saw in Helsinki that the pattern, adapted to different types of buildings, is nonetheless universal. The children enter into an entrance hall that is prepared for wetness. This is a country of snow, of cold weather and of substantial outer clothing. The parents bring the children in, hang their outer gear, which are made in bright colors of rather unusual rubberized materials for handling the wetness. If necessary the boots or outerwear are rinsed. If the suits are wet they can be hung in an ingenious kind of dryer which blows hot air at them. Otherwise they are placed in the child's cubby with the proper symbols, and the shoes are taken off as well. Then, the parents take the children in where along the corridors each child has a clothing place. They take the child's indoor shoes and put them on. Then the parents bring the child to the group, before leaving. The hall is used for hangings as well as getting into or out of one's clothing. It is sometimes used spontaneously by the children for play because it is rather wide and adjacent to their other rooms.

Each group has one large room which is furnished with round tables at which the children eat and little chairs that are appropriate for the 0-3s. Finnish design is apparent everywhere and creates a most pleasing aspect, e.g. the texture of the woods, the wooden floors which are beautifully shined, etc. The rugs were being picked up for cleaning since they were approaching summer vacation. The room with the tables for eating has several play areas along the sides with different types of toys and equipment but staff put out only some of the things each time. The room also has a supply closet with other toys, games and equipment, and the children can ask for things or the "teachers" make changes from time to time in what is put out, to bring variation into the setting. There is also a large higher table in the room which the adults can sit at to do writing or, sometimes, to have a child in a highchair who needs to be fed. There are attractive wall hangings, paintings on the glass and windows. The entire facility features windows and glass everywhere so that outside light can get in and so that rooms seem large and related to one another. Each room also has a child-sized mirror at the proper spot.

Each group's second room is essentially the sleeping room. Where there are small children, the walls are lined with single-level bunks and each has one cot that slides out from underneath. In the area for the 3-6s it is a double-decker or even a triple-decker bunk, fitted with a slide. The children have no difficulty climbing up. The beds are against the wall, so that there is center space. There is also a very comfortable arm chair for an adult who sits in the room and reads while the children nap. The adults whom we saw in two rooms during this process had blankets over them too and were resting as were the children. We were impressed with the sound sleeping, the quietness. On the other hand a child is not forced to sleep and we saw in several instances children near the older end of the spectrum in another room playing with a puzzle or doing something quiet because they did not want to sleep.

In addition to its two activity rooms each group also has a room with two small toilets, two small wash basins, a changing table, a variety of other pieces of equipment. There are storage places for each child's cup and toothbrush, properly marked and, as indicated, for the diapers for the younger children in their own compartments. Above the changing table, for a child who needs to be calmed, is a little toy with a pull string. If the string is pulled a lovely tune plays. Near the toothbrush area there is a poem on the wall, which the children obviously cannot read, but which an adult will read to them if they ask for it, and it explains why brushing teeth is important.

Because the vacation period had already begun, there were a few children missing. The first group that we went to had two nurses and the helper. The teacher was not to arrive until 10:00 a.m. In effect children can come as early as 7:00 or 8:00, and most of them go home between 4:00 and 5:00. They are brought in or dropped off as often by fathers as by mothers and the parents take advantage of their own shifts to keep the days as short as possible. However, the facility is open until 5:30. Arrivals of different members of the staff are scheduled at different times, so that there is a little coverage very early when only a few children are in and there is peak coverage at 9:00 or 10:00. In this case the teacher of the group was in an advanced state of pregnancy, and it had been agreed that she would come at 10:00 for a shorter day.

It might be mentioned parenthetically that Tapiola has two 24-hour day care centers and the authorities are thinking of a special center for evening care because, as shops are open later and as banking hours are extended, parents need such a facility. These personnel, at least, did not seem to be aware of the debate about this that has occurred elsewhere.

This facility is closed in July when practically everybody is on vacation, but there are always a few families who are not on vacation, so two facilities remain open for those who need care. The facilities rotate in this role and this one was actually open last summer to cover for children who were present while the others were away.

As one observed the first group both in their rooms and then later when they were outdoors playing, one saw lots of hugging and holding, enormous amount of interaction and talk between and among the children, more so than with the adults, and children who looked very healthy.

One notes here an interesting contrast with what we saw in Italy where all groups share a "plaza" and all go through the plaza during the day in their various activities, creating the equivalent of a town center. Here, group two and group one share an entrance and certain common resources. For example, there is a room for water play which has something like a wading pool which two or three children can be in at a time, an area elsewhere in the room for playing with clay, places with easels for paint and in general places for making a mess in the room or on oneself and then to be washed up. (The washrooms, incidentally, have a shower so that a child able to stand up can be showered on a hot day or if in need of refreshment and cleaning.)

It is difficult to convey the attractiveness and beauty of this, except one might say that nowhere in our visits in Germany, Italy or France did we see anything superior and most places we did not see anything equivalent. Kreuzberg, in Berlin, yielded one exception. Only the very nicest facilities in Emilia Romagna could be said to match this, although they were different. But one would expect such a facility in a "new town" which is noted for its architecture, landscape design and general design, even though it is now incorporated into a larger city. It should be stressed, however, that the attractiveness was also programmatic and atmospheric, not limited to the physical setting.

Near one of the entrances, closer to the 3-6s, the director has an office, and there is also a small office for the nursery staff elsewhere. It can be used as well for an adult reading to one child, to talk with a child, or to keep a child busy who does not want to sleep when the others are sleeping.

All of the groups are staffed by women, and the "nurses" are quite young. There was one male helper, however--an unemployed young man who was provided six months of a working stipend by the insurance office and returns his labor in response. He was outdoors playing with the children and seemed to fit in very well.

Here, as elsewhere, there was a box of cuddly toys in each room near the sleeping area--children brought their own or adopted some and each child had the same one each time. Similarly, the same bed is used by a child every day and has the child's mark on it.

For the 0-3s, the facility opens at 7:00 a.m. and there are one or two people there. Breakfast is served at 8:00 a.m. Even if children have had breakfast at home, it seems, they want to join the others for breakfast, too. Until about 9:00 a.m. there is free play of various sorts ranging from pushing trucks around, to painting, to working with clay. In general, most of the groups tend to divide into two parts and the adults spread themselves about. Given the large ratio of adults to children, everywhere one could see many one-to-one activities and frequently the very young ones were being held for one thing or another. It should be noted, in fact, that because this was the beginning of vacation there were only seven of twelve children present in group number two and there were similar ratios in the other groups so there was probably much more individualization than would be true at the height of the season.

The floor plan is such that at the back of the building there are large window walls opening to the back so that at any moment the children can see what is going on outside and the staff inside can as well. At about 9:30 a.m. the children begin to put on their clothing or to be helped with their clothing to go outdoors. They go outdoors almost all the time here, even though Finland is noted for its very cold climate and its frequent rains. They may even go out with a light rain since they have good clothing for it: with rubber tops for their playsuits and warm clothing underneath, this is considered alright. They will not go out if the temperature is much too cold, if there is a very heavy wind, or in a real storm, of course. On a normal day, however, they are out playing from 9:30 a.m. to 11:00 a.m., come in for cleaning up and lunch and begin their naps at noon, continuing until 2:00 p.m. At 2:15 p.m. they will have a snack and then they will be playing again until about 3:00 p.m. or so when they will go out again. They will come in shortly before being picked up.

This facility had one of the largest outdoor play spaces seen in all of our visits. It is an enormous area that is compartmentalized and somewhat hilly so that the children, not very many in numbers, are spread over a large space. They can be pushing trucks, kicking balls, playing with ropes, digging in sand, climbing, swinging and all the other things one would expect and more for a 1-3 group.

One is impressed with the fact that indoors and out one has very little sense of heavy engagement of the adults with the children or of their leadership in the activities. It is a facilitating environment with much child-child interaction, very good equipment, adults intervening as a child needs help or takes the initiative, or as the hour calls for a shift of activity. Mostly the adults are standing by, watching the children and not missing cues when needed. For example, when we saw one very small child putting things in her mouth that did not belong there, the adult swooped her up in a relaxed friendly manner and held her in her hands for awhile, having removed the little rock.

These little children were quite capable of going to the outdoor supply sheds and finding the trucks and equipment that they wanted. This of course was again near the end of the year and they had their routines and confidence, but one was impressed with the quality of the play and the clear enjoyment and involvement of every single child there. We doubt that we have ever before seen a group with no children on the periphery, none seeming left out, nobody seeming to be at loose ends, everybody involved, and yet all the ages were from about 1 to a bit over 3, given the end of the year, all of the children active and not requiring much leadership or any leadership in fact from the adults in whose care they were. Perhaps this was an atypical period, with a group somewhat smaller than usual, but what was probably more important is that they had a year to learn interaction, to learn new routines, to become acquainted with the possibilities and they all were obviously enjoying themselves. What is more these are not backward children. They are manually skilled, physically active, and self-confident.

Each of the groups has a symbol at its doorway signifying its name. The symbol tends to be a little wooden figure or puppet which exemplifies the theme. Thus, room number two is known as "Little Violin"; group three has a "Trumpeter" theme. There also was some device at each doorway to identify the staff and the children. For example, many of them used a standard sketch of a train with windows and each window had a child's picture pasted in and the adult pictures were pasted elsewhere. There were variations. The group identification with the theme and with friends is very strong. They begin with a group when they come and, given the age range, they can remain with the group until they become too old, so a child can typically be in a group for two or three years, with the only shift taking place when they reach the 3-6 range with somewhat larger groups.

It should also be added that the group is not limited in its program to the facility itself. The outdoor time can sometimes be used in other ways. For example, they may take a walk in the woods which are adjacent to the large outdoor play area belonging to the center itself. In fact, the 3-6s can play at the outskirts of the woods if they like. But very often there are trips for the group to the center of town, a storybook place in a model new town. They might visit the bank, the library, the culture center. There are special concerts for child care children and children in the schools. Sometimes they visit another center. It should also be noted that since the outdoor space for the 3-6s is adjacent to that for the 0-3s there can be visiting back and forth, particularly if there are siblings in the other group. Once in a while, at the time of a child's birthday, a mother will invite the child's entire group to the home for a birthday party.

At the entranceway for each group there is a bulletin board, so that the parents can see the program for the week and the month and the year and get some sense of what the children are doing. Menus are also posted (and there is provision to meet the needs of children with special diets). In addition to the bulletin board parents are provided at the beginning of the year with a sort of manual about the center which explains the program, what is done and the staff.

Staff have a conference with the parents at the beginning of the year and periodically during the year as appropriate. The conference with the parent takes place at least twice; in effect there is a shared plan for relating to the child and emphasizing what the parents think is important. There is a big meeting for all parents at the beginning and then meetings with groups of parents. It is mostly the mothers who come, although the fathers are more and more doing pickup and occasionally the younger fathers come to the meetings as well. There also are events in which families participate, at Christmas, spring holiday, Mothers Day, Fathers Day. One did not get a sense here of very heavy parent involvement in the sense of the governance of the center, but there is a group of parents who meet in support of the center and carry out events for fundraising to provide supplementary funds. The director seems to have a very adequate budget, and regards the activity as more important probably than the sums produced. The parents do not have to provide any particular things for the children who come here, since all the items described previously as being available in the cubbies and in the various rooms are provided out of the regular center budget. The one exception is that the parents bring the diaper supplies for the little children.

The third group of the 0-3s, symbolized by the "Trumpeter" figure, has its own entrance, the same room set-up and the same equipment as the second group. There was one highchair next to the large table since they had one child still using it. As in the instance of the other two groups, despite the similarity of the room layout and the basic equipment, different colors, different hangings and different arrangements make each seem separate. They even had a supply of little picture books in the toilet, so that the child could look at them if he or she wanted to while sitting there. These are disposable books. A rather attractive and unusual comb holder had been crocheted by one of the staff so that each child's symbol was shown where his or her comb was kept. Each child of the younger ages also had his own pacifier box. When we commented on the very good shape of everything, how clean it seemed etc., the response from the director was that the personnel took care of it and kept it pretty because they found it a lovely environment in which to be. The laundry room was very active, e.g. towels and other things being washed and dried and stored. The helpers rotate, each one in charge of the laundry room for a week. In addition to the helpers described above there is one cleaning lady for the facilities and three working in the kitchen. The kitchen was a modern facility, each of the helpers was in a uniform, and it was the cleanest and best-arranged such facility that we had seen over the year. The three on kitchen staff have all been to a special cook school and we rather suspected that it was a larger staff than necessary for the some hundred people eating here. These well-trained cooks, each with three years of training, were probably more than needed to assure nutritious meals. Yet, the office set the menus. Here they order the food and they had extraordinarily good storage and refrigeration capacity for each type of food. They also were set-up to meet the needs of special diets for children, e.g. those sensitive to dairy products, those with diabetes, etc. There is one vegetarian child, however, who must bring his own food. Part of the explanation of the high level of staffing is that somewhere later on they may be providing food for a smaller facility nearby as well. We found this throughout, i.e. larger facilities may provide food for two or three smaller ones which have only modest kitchens for assembling the meals, providing breakfast and snacks. Finland guarantees each child a warm mid-day meal.

Another feature of this facility is that the children even in the 0-3 group, as they are able, get the opportunity to help set the table, and even to serve. A child is assigned for a few days or a week, depending on age. There is a special bulletin board that shows the mealtime arrangement, and the children's symbols are placed in the center of the board if they are the helpers for that day or for that week. The others all bring their dishes back to the cart at the end of the meal. It was extraordinary to see the little children all doing this in orderly fashion. We talked with the staff about the self-feeding of children and were told that even 10 and 12 month-old children feed themselves well. They usually cannot when they arrive, but they see others doing it and insist on having a spoon and trying. Gradually they gain the skills.

Staff meet once a week within each group. At that time, their children are joined with the adjacent group of similar age and the staff there are responsible for them. Once a week there is a meeting of representatives from all groups. A teacher or a nurse is sent to that meeting and they discuss shared problems and issues. In fact, the meeting may also discuss (within the own group) problems of a particular child or plans. Moreover, there are periodic queries from the central office or directives which require a group discussion.

The woodworking room has one teacher, who was specially prepared for this work and mostly serves the older groups. It is used for various kinds of construction, not for carpentry alone, but actually has a pretty good set of tools and proper equipment.

Situated between the infant groups and the preschool groups is a very large room, a kind of hall or perhaps we might call it a gym, for sports, music and very active play. It has a high ceiling, a large open area, climbing bars, mats, etc. and a piano. However, it is so set up that even though there are climbing ropes as well, everything is over on the side or stored so that when necessary there is a large space which can be used for group activities and even for an audience and performance. Child minders (family day care providers) from the neighborhood may also come with their children and use these facilities when they are not otherwise scheduled. The scheduling is quite clear and sharp so that it is known when it is free for such use, and apparently it is very popular with child minders. Since the room is used for parties as well it even has colored lights, something we were told was unusual for a child care facility. It is a very attractive room because, in addition to the high ceilings, there are long, large windows so that it is very light. The bottom parts of the windows have lovely scenes painted on them by staff.

Another shared facility outside this hall is a small child-level kitchen. There is a real stove even though it is not too high for a one-year-old, cabinets, places for dishes and supplies, etc. Thus a staff member and a few children can go over and they can make salads, bake cookies, and so on. This facility also is scheduled regularly among the five groups. There is a small sink so that the dishes can be washed and the table set by the children. There is also an ingenious drying cabinet, of the kind characteristic only of Finland, in which washed dishes are put on racks right above the sink and the racks have several levels. The door is closed so it is like a closed kitchen cabinet, but the dishes drip down and in 5-10 minutes are all dry.

One of the 3-6 age groups has its own entrance and there is a sign over the entrance saying "entrance for the 3-6s". The general entrance layout is the same as for the younger children, however. To conserve space the observation report is not included here, where we concentrate on the under-3s.

We asked whether parents can drop in at will. The answer was that this is so but seldom happens. They took the question to ask whether parents were pressured to be here a lot and to do a lot. They try to avoid this because the parents are working and busy. They said that, in contrast, the private kindergartens tend to push more for parent involvement. At the beginning of the year they give the parent plenty of time for the separation. They have the group meetings and they have the big meeting at the beginning and at the end of the year. In this place a parent group has been formed and has developed recreation events and auctions which raise some money for extra activities, as indicated earlier. However the director said that there is more and more talk about increased parent involvement even though parents have not been pushing it. Some urge more education for the parents so that they will want involvement. We did not have the feeling here that the director saw this as a very important priority. On the other hand there is nothing about this facility which is closed to parents. It is all open and can be visited and dropped-in on. Full-time two-parent workers do not have much dropping-in time.

The families pay income-related fees for tuition and for the food. If there is no worker in the family, e.g. both are unemployed or students, there is no payment at all. Total cost to the society for a place is about FIM 4,000 monthly (in U.S. $988 at the time of the visit). Parents pay about a quarter of the cost if they are at the upper income groups. The highest fee is about FIM 1,300 ($321) a month (16 percent of an average female production worker's wage). However, the typical parent here is paying about FIM 250 (3 percent). Now, in financial stringency, the ceiling is going to be raised somewhat. Even at present, there is some small differentiation with the parents paying about FIM 1,100 for the youngest child, at the highest level of income, and about FIM 1,300 for the older child. This is somewhat unusual, given the staffing ratios at the different ages. It reflects the government's decision in the early 1980s to give initial priority to the under 3s.

In a discussion with the director and the supervisor about parental choices as between the options, they said that parents very often did consider what to do and sometimes came and asked. What HL tells them to do is visit the several possibilities, e.g. center care, normal family day care, and the group type of family day care, before choosing. She also stressed that if they make a choice they can also make a change later on if they think they have made a mistake. If they choose home care, they save the fee and have the home caring allowance. After age 3 they are not collecting a home care allowance; that is not an issue. Some use private care, an option for a small subgroup, but they tend to do it only because no public place is available. Or they may have some ideology about it. Hence it is clear that parents participate more and seem to have more influence on the private facilities. These are more expensive.

ON THE GROUND - MATERNAL AND CHILD HEALTH

1. Kirkkonummi, Finland

This city of~26,000 is about 30-45 minutes from Helsinki by train, depending on whether it is a local or an express. We were met at the station by the chief nurse, MM, a woman in her 50's who immediately accompanied us a few hundred yards from the railroad station to what is essentially the administrative offices of the public health center, the outpatient clinics, and a small 80-bed hospital, attached, all in a medical complex which is closely integrated. For example, the some 250+ staff all eat in one cafeteria. The child health center itself, which we were subsequently to visit, is in a simple, small, bungalow-type building, detached, and just a short distance from the large, impressive, and by American standards rather lush and lavish administrative building with its outpatient and inpatient facilities. We had a tour of the building, which has outpatient sections, specialized laboratories, room for a psychologist, and a special connection to the hospital wing.

The city is divided into six areas. Each area has two to four medical doctors serving a population of 4,000-5,000. Patients come in when there is illness, and in each instance there is a comfortable waiting room and a nurse, much as though it were a doctor's private office. Each locality also has its assigned public health nurse. When they see children for well-baby care, these doctors go over to the child health center, which also includes rooms for prenatal visits and for family planning. Mrs. M provided us with two sheets (see pages which follow). One outlines the scope of the services; the second offers 1991 statistics. She made her presentation in accord with the outline on this sheet.

Thus, in their prevention work, they begin with the family planning services for young girls 13-18 and of course continue with mothers after delivery. They offer sex education, advice about contraception, supplies, all in a preventive environment. Mrs. M explained that it is quite ordinary for girls 13-18 to come in to the public health nurse for family planning advice and

EXHIBIT A

SERVICES TO CHILD HEALTH CENTERS

KIRKKONUMMI, FINLAND

1. Family Planning
   (for girls 13-18 and mothers after delivery)
   - public health nurses
   - doctors
   - advice and supplies

2. Maternal Welfare
   - maternity advising by public health nurses and doctors, approximately 16/18 contacts per pregnancy
   - maternity package
   - maternity leave and salary replacement
   - maternity training courses, 3-4 sessions (public health nurses, psychologist, social worker, physiotherapist)

3. Child Health Center
   - visits by public health nurses
   - office contacts with public health nurse and doctors (see text re: frequency)
   - mother-child groups

4. For Illness
   - visits to general practitioner
   - hospital availability

5. Dental Care

6. School Health Care From Age 7

EXHIBIT B

KIRKKONUMMEN HEALTH CENTRE

1991 Statistics

Population Overview

- under age 1	421
- 1-6	2,658
- 7-14	3,863
- 14-64	20,742
- 65-74	1,205
- over 75	698
TOTAL	29,587

Personnel

- doctors (GP's)	19
- Public health nurses	21
- Social workers	2
- Dentists	10
Total (inc. non-prof.)	248

Treatment and care

Visits to doctors	52,487
Visits to nurses	11,980

Preventive Services

Family planning:

Visits to public health nurses	3,036
to doctors	943

Maternity advice:

Visits to public health nurses	7,430
to doctors	1,562

Child health:

Visits to child health centre	9,233
to doctors	3,711

School health care:

Nurse contacts	13,782
Doctors contacts	2,093

Group sessions:

Family education sessions	149
Mother-child groups	44
Health care advising in schools	141

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contraceptive materials. School nurses also lecture on contraception. Children here are believed to begin their sex lives on average between 15 to 16 years of age, at least that is the most recent study result. They can come and ask for contraception and are not required to tell their parents. If contraceptive supplies are needed, the nurse who does the sex education arranges for the doctor who services the family planning clinic to actually see the girl and provide the supplies. She could not provide exact data on out-of-wedlock births because some of the people in this area do take up the choice of private hospitals and there is no centralized statistic. All this is a free service. The state (national government) pays 40-50 percent and the community the rest. The only costs people have arise if they go to private doctors.

Boys get their sex education in the school and they also can get education on AIDS and condom supplies. Every public school has a public health nurse. The nurses are shared if the school registration is under 500.

MM is obviously proud of Finland's child health service. She, as others, mentioned Arvo Ylpp, who died last year at 104 and was the charismatic leader and guide of this entire development. The emphasis is on a free and universal system which integrates the family doctor, the health centers for children, the prenatal care and family planning in the health centers, and the hospital system under one overall administration. It is all paid for out of tax funds.

There is no problem here about involving the mothers in prenatal care. About 98 percent come for check-ups. We asked about how take-up was assured and were simply told that "it is the usual thing to do." It is free, paid out of tax funds, and they doubt that people come for the maternity packet. Nonetheless, the packet is valued (see previous description). The description above outlines the philosophy about maternity and child health visits based on the interview in the national office. According to this informant, in Kirkkonummi a pregnant woman will be seen sixteen to eighteen times by public health nurses, including midwifes, and doctors. When we raised a question about it she said that they are discussing the possibility that the visits are excessive. This is precipitated by the fact that Finland is now in economic difficulty with a need to cut somewhere. They will perhaps cut the number of visits, allowing more for mothers at risk. Most of the visits are to the public health nurse, but some are to the doctor. Some, instead of using the doctor here at the clinic, continue with their private doctor - apart from their mandated visits to the public health nurse which, incidentally, assure the packet at the time of birth.

With regard to the maternity leave and the parental leave her estimate is that about half the mothers here use the home care leave for some portion of the time. However this commune has been adding about FIM 1,000 ($247) to the FIM 1,000 from the state; they are now cutting it back as have many other jurisdictions because of financial stringency. The town contribution will now be about half what it was earlier.

We discussed the culture about the home care leave in some detail, and were joined here by OL, the social worker. Mrs. L is now pregnant, has been thinking about it and so she could share her thinking as well. They both agreed immediately that career women are different than the uneducated. The latter take the full period, the former less time. However, economic issues could be important in the family's decision. They acknowledged that the current government's shift, raising the amount for those who stay at home, represented a change from a neutral position to one biased further in favor of home care. One could interpret this both as a reflection of the conservative government and less reliance on coalition, and also as a reflection of the fact that there is unemployment. Mrs. L expects to stay home for about a year and thinks that it is typical for people with career jobs. She noted, for example, that several female doctors stay home that long. On the other hand, Mrs. M said that some nurses she knows stay home as long as three years.

When the mother gets home from the hospital after childbirth she is visited by the public health nurse whom she saw while pregnant and/or by the midwife who supported the birth in the hospital. A transfer is then made to the area public health nurse. At the time of the first visit the child and mother are examined, there is discussion of breast feeding, as needed, and there is attention to mother-child relations. Everybody gets a first visit and some get two or three. Selectively, if there are such problems as handicap, alcoholism, or anything else which seems to occasion it, there will be more visits. Under normal circumstances, the mother brings a 1 month old child to the child health center. A vaccination program begins at age 3 months. A typical child is seen eleven times in the first year by the nurse and three times as well by the pediatrician. The first examination by the doctor in the child health center is after two months, the second after eight months and the third after a year. After that the child comes to the child health center annually for the nurse and every two years for the doctor. Care during the year, if the child is sick, is by the physician who is covering the family. He could of course be the same doctor; but this is not necessarily the case. Again, a sick child is brought to the doctor, wrapped in a blanket if necessary. There are no home doctor visits here. An emergency will be handled in the hospital.

If the mother should be ill and not able to manage, the home care service bureau will send the equivalent of a home health visitor, paid by the municipality, to give help when the mother comes home with the child.

The "big checkup" takes place at age 5, as part of the "health control system" before the child enters school. At that time they look into school readiness generally because it gives them two years to do things as needed before the child goes to elementary school. However, it is very clear that the children are followed very closely and their records are always available in the child health center. Although as indicated there is a visit to the nurse once a year after the first year, as needed the nurse will call, there will be extra visits, and there will be a plan for more frequent visits. As much is true of the preventive role of the doctor. All the doctor's preventive work is done in the child health center. The other visits to the doctor are when there is illness and that is in the building for "sick care.".

Here the midwives are public health nurses and thus they play both roles with regard to the post-maternity visits. Two area social workers work in close cooperation with the nurses and doctors.

The child health center has organized groups meeting weekly, the sorts of groups that one hears about in many places. They deal with the usual daily concerns of mothers about child play, norms, nutrition, accidents. Interviewees noted, however, that people are hardly dependent on the public health system here. The churches actually have very elaborate mother and child groups and various kinds of courses once or twice a week. These are very popular. The child health clinic has a "mothers' coffee hour" where mothers come and interact. The social workers are planning something like that as well once a week. There is a psychological and psychiatric service on which they may both call. We in fact were joined by the local child psychiatrist who accompanied us on the subsequent visit to the child health center and confirmed all of this.

2. The Child Health Center

In American terms this is a "well-baby facility". If the child is ill the child is brought to the doctor in the other building, as noted. It may be the same doctor, they simply do not have sick children in the center. The stress is on preventive work. Here we were joined by the nurse in charge, one of two. This women in her mid-forties has two children of her own in their twenties. She is pleasant, intelligent, open and extraordinarily enthusiastic about her work. The bungalow-type building has four major rooms besides waiting space and service rooms. The first is used by pregnant women at the time of their prenatal visits. Next to it is a room used for the family planning consultations. Then there are two rooms for the public health nurses who deal with the children on their visits. It is a typical examining room for a pediatric clinic but one is impressed as well with the excellent files. Each child in the area is represented by a blue or pink folder. Cumulative records go from the time that the child is born until the child enters elementary school and is taken over by the school nurse. Everyone is seen.

Again we asked how they managed to get everybody into prenatal care and then again to visit regularly on the schedule after the home visits. The response given again was "It is the thing to do." It never occurs to a family not to come in with their child. The child health center in effect see every child and has a health record on every child. What is more, if people do not come when expected for follow-up, the nurses will phone and then people will come in. The stress here is on monitoring the child and giving needed preventive advice. The area assigned is of such size that there are a hundred children born each year in this nurse's territory.

The entire service is voluntary, as is the taking of the vaccination at the mandated times. If the mother does not want a particular service, or the vaccination, the nurse will talk with the mother. She has never had a refusal. She doubts that the birth package, despite the fact that it is quite valuable, is what brings people in for the prenatal care. Here, too, "it is the thing to do."

So intent are they on protecting people's rights to refuse that a child will even be admitted to school without a vaccination. They know there are philosophical and religious objections. More recently the talk has been that since they have wiped out all the contagious diseases why should the vaccination be taken. Staff do know, however, about the recurrence of diseases elsewhere and therefore try not to let the intensity of the program be diminished.

We discussed with this nurse the way in which she organizes her week, given her various responsibilities. She said each nurse does it in her own way, on her own. Her constraint is that there are several meetings that she must attend. Beyond that what she does is in accord with the flow of need. She sees people in the office for the mandated visits with the children each day and then keeps some time each week for home visits. If there is serious need or something special she will go out after

4:00 p.m., when they usually close up. She also explained that in fact the area public health nurse does not visit everybody in those first two weeks after childbirth. The midwife visits everybody and she, too, is a public health nurse. The district health public health nurse will do a definite visit for every first child, but will not necessarily go if it is a second or third child. Then, she will take her cues from the midwife. However, she will visit a child if there is any reason to do so. Parents, moreover, are always willing to be visited.

She will make a visit, for example, if she has heard some "social" reasons to do so, e.g. a mother with problems or a family in difficulty. She refers easily to the social worker as does the social worker to her. The doctor will make a referral to pediatric psychiatry if needed.

The way she thinks of the schedule is this: she sees the child at the clinic every month. The doctor sees the child at 6 weeks, 4 months, 8 months, 18 months, 3 years and about 5-1/2 years. After the first year, the nurse sees the child in the in-between times. They may call here and talk to the nurse if the child is sick because they know the nurse and the nurse knows the child's record, but if the doctor has to be seen because of illness etc. they will bring the child to the main building. (There is a unit of doctors who visit the ill elderly at home but other people come to the doctors' offices or to the hospital.)

She also meets with some of the mothers in groups, usually when the children are under age 1. They discuss everything about child rearing: eating, crying, colic, etc. The nurses arrange these groups for their mothers. On the other hand they can go to "ready groups" in the churches and elsewhere. The nurses themselves are invited to give lectures before such groups.

This nurse, too, made the kind of comment that we have been hearing, in many places; there is a lot of interest in group support because the mothers are far from their mothers and grandparents and they have nobody close by with whom to discuss things about young children. Again, it is a free service, "the right thing to do," and "normal to come here."

Since the area is divided into sections, most people can walk to their equivalent of this child health center in the bungalow-type building. On the other hand, it is a very large territory, 300 square kilometers, and 50 kilometers north to south. Some people are therefore not too close physically to centers.

As an aside, as we wound up, the nurse mentioned that most of the mothers here now breastfeed for at least six months and some for a year. This was not the case twenty years ago.

To sum up:

There is universal coverage of child health services as a public service out of taxes. It is doing just what universal services are expected to do: It has become a normal "public social utility" and everybody uses the prenatal care and the child health service. Moreover, with physicians on the public payroll, everybody has adequate preventive coverage and coverage for illness but they are not blocked from using private doctors if they wish. Nurses reach out, do case finding, but have cut back the home visits to the early ones, and after that people bring their children to the child health centers. They have frequent contacts, a good vaccination routine. There is good integration with the social work service. However, none of this involves the big city and ghetto problems which we know in the United States and which complicate it all. The fact that one is going to a doctor in a public service in what might be called an out-patient clinic doesn't seem to carry any stigma at all. We are talking here about attractive buildings, comfortable waiting rooms, and respectful -- unrushed -- staff. As is noted on the statistical sheet, this commune had only four hundred and twenty-one children under one year of age for the statistical year of 1991.

CONCLUSIONS

Finland's exemplary maternal and child health, infant mortality, and low-poverty records probably may be ascribed to its general economy, environment, and culture as much as to its family and child policy, but that policy clearly is the vehicle through which the society realizes its possibilities. We note, for example, that Finland is not a leading country in adult health, especially male health. Its record for alcoholism, suicide, cardiovascular disease suggests that whatever the context and opportunities, specific policy may matter!

Apart from the general social infrastructure of a Nordic welfare state, including health coverage, housing, and income transfer provisions, Finland has developed particularly strong family and child policies in the 1980s: child allowances and a special allowance for the under 3s; paid maternity/ paternity/ parental leaves followed by the possibility of an extended leave with a home care grant; a guarantee of child care space for infants and toddlers; a projected guarantee of space for the 3-6s; child health visits and centers to monitor children and provide preventive guidance.

While not formally located in one spot in government, this policy package, with its particular emphasis on the under-3s has emerged over a long period of coalition government, guided by cabinet and parliament, and nationally the responsibility, most recently, of a ministry and a board with social welfare and health responsibilities.

As a parliamentary democracy (and one that long functioned under unusual external political pressure) Finland probably found itself better equipped to undertake coherent and cumulative policy strategies than is our complex federal system with its checks and balances. Yet we in the United States feel that our system's advantages outweighed the problems and that we should be able to respond to the public will.

Finally, Americans will note that Finland is a small country in population, lacks our heterogenity, and therefore has not coped with some of the implementation complexities which would impede similar efforts in our cities. They also will note that Finland taxes itself more than Americans do, and thus can undertake more (Finland's tax receipts were 38.1 percent of GDP in 1989 and U.S. 30.1 percent and the average Finn had a disposable income as a percent of gross pay higher than that of a U.S. citizen, the exact difference varying by family types.) On the other hand, comparing by purchasing power parities, per capita GDP in the United States led that in Finland in a significant way.[30] The issue in part, at least, is political will.

Thus as they consider launching an under-3 policy discussion, U.S. citizens might well give attention to several aspects of Finland's child policy: its solid paid, maternity - paternity - parental leaves; its decision to offer the parents of infants and toddlers the option of home care and publicly ensured day care, both publicly supported; attractive day care for those ages 1-6; an admirable system of maternal and child health. Finland may not be a template, but it is certainly a challenge and a stimulus.

NOTES

[1] Alestalo and Uusitalo, 1986, p. 276.

[2] Since completion of our "case", there has been some slowdown in meeting child care commitments, as noted below, and child tax exemptions were abolished on January 1, 1994, while increases in child allowances were introduced to favor low-income families.

Unemployment reached 20 percent, the highest among the Nordic countries, then declined a few points and unemployment benefits were limited to 500 working days (over 80 weeks) and thus still very generous in U.S. terms). There were cutbacks, too, in some sickness and housing benefits and in some local government assistance - as Finland's budget deficit was exceeded only by Sweden among the Nordic countries.

[3] Haataja, p. 29, updated.

[4] Halonen, 1987, p. 15.

[5] In effect the Social Democrats appear to have taken advantage of the interest of the governing coalition in serving under 3s by trading support of home care for the day care guarantee for under-3s. They knew that it would be far easier to win public support subsequently for kindergartens for the 3-6 group.

[6] Kamerman and Kahn, 1991, _Child Care, Parental Leave, and the Under 3s_, p. 168 table.

[7] Ojala, 1989, pp. 95-101.

[8] Ojala, 1989.

[9] Ojala, 1989 and Association of Nursery Teachers, _Children in Finland_, 1988.

[10] _Children in Finland_, 1988. p. 2.

[11] _Ibid_., p. 3.

[12] Ojala, 1989.

[13] Ojala, 1989, pp. 93-95.

[14] Ojala, 1989, p. 98.

[15] Ojala, 1989, p. 115.

[16] Elgaard, Langsted, and Sommer, 1989; and Nordic Statistical Supplement, 1991.

[17] Nordic Council of Ministers, 1991. Also *OECD in Figures*, updated.

[18] Haataja, 1991, p. 1.

[19] Halonen, 1987, updated.

[20] Haataja, 1991.

[21] Alestalo and Uusitalo, 1986.

[22] *Ibid*., pp. 205-208.

[23] *Ibid*., pp. 212-213.

[24] *Ibid*., p. 226.

[25] *Ibid*., pp. 232-233.

[26] Haataja, 1991, p. 1.

[27] Alestalo and Uusitalo, 1986, p. 233.

[28] Kamerman and Kahn, 1991, "Government Expenditures for Children and Their Families ...".

[29] Hulkko, 1992.

[30] *OECD in Figures, 1992*.

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SOCIAL POLICY AND THE UNDER 3s, FRANCE

A CASE STUDY

Table of Contents

PAGE

INTRODUCTION....................FR 3

FAMILY POLICIES IN FRANCE ....FR 6

POLICIES FOR THE UNDER 3s....................FR 16

1. Maternity and Parenting Benefits....................FR 16

2. Family Allowances ....FR 17

3. Child Care Services....................FR 20

4. Family Support Services....................FR 26

5. Maternal and Child Health Services....................FR 30

CONTEXT....................FR 320

1. Demography....................FR 32

2. Expenditures....................FR 35

THE POLITICS OF SOCIAL AND FAMILY POLICY....................FR 37

ON THE GROUND....................FR 40

1. Jardin d'Enfant Municipal....................FR 40

2. Crèche H______....................FR 49

3. École Maternelle O_____....................FR 58

FAMILY SUPPORT SERVICES....................FR 68

MATERNAL AND CHILD HEALTH SERVICE....................FR 74

1. Family Support in an MCH Context ....FR 78

CONCLUSION ....FR 82

NOTES....................FR 86

REFERENCES....................FR 88

INTRODUCTION

France has an explicit family policy that was shaped as a system of public social policy at the end of the 1930s, reaffirmed following World War II, and involves a rich array of child-related cash benefits and services. The cash benefits are the most extensive and generous in the world and the services among the most extensive.

Five objectives have dominated French family policy over these years:[1] (1) "solidarity" - to compensate families for the economic costs of child rearing; (2) pronatalism - to encourage a higher birth rate; (3) "social justice" - to redistribute income to low income families with children; (4) in more recent years, in addition, to protect parental choice among family types and life styles, to protect the economic situation of families regardless of whether parents choose to work outside the home or to remain at home to rear children; and (5) to protect the well-being of children. In 1988, the then Secretary of State for the Family characterized French family policy as an active policy that promotes family values such as solidarity between the generations and a sense of responsibility (European Community, 1990). The priorities among these goals, especially between the second and the third goal, have varied over time. The political "right" has continued to stress pronatalism while the "left" has emphasized social justice.

Multiple categorical cash benefits have been the preferred device for providing family benefits. Although the single most important family benefit is a universal family allowance, the major stress over the last decade and a half has been on income-tested, categorical supplements. Special allowances for orphans, handicapped children, children under age three, single parents, and so forth have been the pattern and continue to be so. All new allowances created between the mid 1970s and mid 1980s were income-tested and when universal benefits were given attention in the 1980s the context was renewed pronatalism (Teitelbaum and Winters, 1985; European Community, 1992).[2]

French national plans in the 1980s continued old as well as new priorities: young families, large families, poor families, and working families. Current goals emphasize: supporting the rearing of the very young child; promoting the birth of the third child; reducing child poverty; facilitating the reconciliation of work and family life.

For some time, French family policy has had a special focus on the very young child (under age 3). Apart from paid and job-protected maternity leaves for working women which were first enacted as part of sickness insurance benefits in 1946, and the allowances provided pregnant women linked to obtaining prenatal care, the French family allowance system, increasingly, has paid special attention to the very young child. This special focus began first in 1972 when a cash child care benefit was first provided to working parents with a child under age three (this benefit no longer exists) and was extended in 1977 when an income-tested family allowance supplement was made available to families with a child under age three or three or more children. (The first part of this allowance has since been superseded by another allowance, APJE (see below). In the 1980s, the focus on the under 3s was increased with the establishment of a series of new categorical cash benefits targeted on the very young child, increased attention to child care services for the under 3s, and emerging attention to a more broadly-focused early childhood or family support service.

Government responsibility for family policy falls under the following government agencies: a "junior" or "sub" Ministry for Family Affairs (under the Ministry of Solidarity, Health, and Social Affairs whose name has varied in recent years but not its competencies); a High Council of the Family and Population - a national commission responsible to the President); and the National Family Allowance Fund (CNAF) which is the national agency responsible for the management of direct financial assistance to families (European Community, 1990). In addition, the Ministry of Education has responsibility for the French universal system of preschool education for the 2 to 6 year olds, the Ministry of Health has responsibility for Maternal and Child health services (the universal, community-based system of well baby clinics serving pregnant and postpartum women and children under age 6) and child care services for the 0-3 year olds. And the Ministry of Social Affairs has responsibility for benefits and services for troubled children and their families. France also has an influential national association of family organizations which includes in its membership both organizations that represent and advocate for family matters and family-serving voluntary organizations.

FAMILY POLICIES IN FRANCE

French family policies include both cash benefits and services. We begin first with a listing of the cash benefits and an overview of the history of their development. We then describe the services: child care; family support; maternal and child health. Here, the focus is on children generally while in the next section we focus specifically on the under 3s.

The French system of family allowances includes a large number of categorical cash benefits some of which are universal, some that are particularistic as to category of need, and some that are selective as to income. In addition, there is a family-unit based tax system.[3] Since 1945 when the current system was first established, the benefits have increased in number, in specificity (they have become more and more categorical), in selectivity (more income-tested), in coverage (children are now covered until they are 18 and regardless of the employment status of their parents), but do not yet provide coverage of first children under the basic family allowance. Family allowances are tax-free and the benefit levels, which are adjusted annually, are linked to prices and related on a formula basis to a base amount equal to about one half the French minimum wage.

More specifically, French family benefits include:

- the basic family allowance, a cash benefit provided regardless of income for each child beginning with the second, up to age 18, and varying in amount by the child's age. All French families with at least two children qualify for this benefit;

- an income-tested supplementary family allowance for large families (those with three or more children) aged three or older;
- * - a young child allowance (APJE);
- * - a parental education or child rearing allowance (APE);
- * - a parental education or child rearing leave;
- an orphan allowance for children without one or both parents, for whatever reason.
- a single-parent allowance that is means-tested and is available for one year or until the youngest child is age three;
- a housing allowance, income-tested, to offset some of the costs of housing, either rental or owned;
- * - a maternity leave and cash benefit;
- * - two allowances that subsidize the costs of in-home care of a child under age 3;
- a special allowance for children returning to school in the fall;
- a special allowance for handicapped children being reared at home.

In addition, since 1988 there has been a guaranteed minimum income benefit that is means-tested and available to all, both those with and without children, contingent on demonstrable attempts to enter or re-enter employment. Working women gain two years credit toward their pension for each child brought up for at least nine of his or her first sixteen years.

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* Targeted on the under 3s and their families and described in more detail, subsequently.

Moreover, the French income tax system is based on a family unit concept, Family Quotient, in contrast to a joint filing unit as in the U.S. or a single filing unit as in Sweden. As a result, large families are advantaged. Income is pooled for the family and allocated on a formula basis to children as well as adults in the family; then the tax is calculated. There is also a child care tax credit to offset some of the costs of child care for working parents.

Family allowances (FA) originated at the end of the 19th century as wage supplements provided voluntarily by private employers to their workers. They were used selectively to raise the wages of employees with families without raising all wages. During the 1930s, interest in family allowances grew as a pronatal device as well as a wage supplement. Almost all employers were required to contribute a percentage of their payroll into an "equalization fund" to pay benefits to all workers with children; and farmers were covered as well. However, organized labor opposed FA until after World War II, viewing them as a device for maintaining low wages. Nonetheless, by 1939 French family policy was viewed as being an explicit component of public policy.

Following World War II, FA were institutionalized within government, becoming a key part of the major new social security legislation passed in 1945 and 1946. The Family Quotient income tax was established in 1945 also. FA benefit levels were linked to wages, but the linkage was changed later to prices although the other insurance funds (pensions and sickness/ disability/ health benefits) remained indexed to wages. By 1949 a National Family Allowance Fund was established as one of the three major social security funds.

From 1945 to the end of the 1950s is described by many as the "Golden Age of Family Policy" in France (Laroque, 1985). There was a high degree of consensus across the political spectrum concerning family benefits. The goals of pronatalism and solidarity were strongly supported. All benefits except for the housing allowance were universal. Benefit levels and contributions rose and by the end of the 1950s they constituted a very significant part of family income. More families received benefits and one analyst reported that 90 percent of families with two or more children received a family allowance package equal to 45 percent of the minimum wage.

The fifteen years between 1958 and 1973 were a period of adjustment in the family benefit system and of erosion in the value of the benefit package and in the relative position of FA within the social security system. With a new government in power, different priorities emerged. The baby boom had eliminated the historic French birth anxiety. There was no new family benefit agenda. A new discussion began about shifting support from all mothers to mothers of very young children only, but no new legislation was proposed.

Of particular importance in the 1960s was the growing concern with "social justice" as an objective for FA. Initially, FA were viewed as supporting a "neutral policy" with regard to family income (except for housing); the overriding purpose was to compensate parents for part of the economic costs of rearing children. Universal benefits began to be characterized as leaving intact existing social inequities. Research revealed that FA had been effective in achieving horizontal redistribution and birth rates were no longer an issue. What now emerged as a concern was the failure of family benefits to help poor families.

The 1970s were characterized by increased concern with social justice and growing recognition of the needs of working women and their problems in managing family and work responsibilities. The first income-tested measure was passed in 1970, an orphans allowance that was subsequently modified (1975) to take account of the needs of single-parent families generally, including separated, divorced, and never-married parents. In 1972 an income-tested child care allowance for families with working mothers was introduced. The 1970s also brought new interest in in-kind benefits, in particular preschools and child care services.

The history of family benefits since 1973 is described as the end of the golden age and the end of consensus on FA. The economic crisis following the energy crisis led to resource constraints and the baby bust led to renewed concern with the birthrate. The first real family policy debate emerged in France about whether FA were to be primarily pronatalist or primarily redistributional. The left stated that family policies should be neutral towards the birth rate; the right insisted that a higher birthrate was an essential goal. The left stated that if social justice was the objective, the family quotient tax system should be eliminated while the right insisted that for pronatalist purposes it must be maintained. The left insisted that for both natalist and social justice reasons the first child should be covered; here there might have been agreement, but economic constraints precluded new legislation in the 1980s. Both right and left agreed, however, on removing the last link between employment and FA. This link had been eroded over time; however, the final break came when legislation was enacted in 1978 explicitly eliminating any relationship between employment status and basic FA. FA now became explicitly a child benefit, not a family benefit; the transformation from a claim of workers to a wage supplement to a right of children to some minimum income became a principal established in law.

Part of the end of consensus can be attributed to the effects of social change as seen in what happened to the family during these years. Initially, the French had a "model" family for family policy to support: a couple with a man working and a woman at home caring for three or four children. This model justified a generous and coherent family policy that was characterized by progressivity of benefits to later children, encouraging women to remain at home, and benefiting the better off families through the tax system. Improved contraceptive technology left women able to choose how many children to have, when to have them, and whether to take advantage of the available jobs that came with economic growth. With fewer children and more education, women moved increasingly into the workforce.

Changed patterns of sexual relationships, marriage, and divorce led to more one-parent families. Illegitimacy became more frequent and more acceptable even if the consequences for both mothers and children were to be worse off economically. Clearly, the "model" family was no more.

Even pronatalism took a different tack in the 1980s than earlier. In the 1930s the concern was to get couples to have at least one child; 23 percent had none. In the 1970s very few couples had no children but even fewer had large families. Consequently, the new pronatalism of the 1980s focused on "the third child" and on helping women manage work and family life, especially when they have very young children, under age 3. The basic assumption was clearly that by age 3 children can and should go to preschool (the universal, public, free école maternelle described below). Family policies of the 1980s and 1990s were to be directed toward supporting "choice" for mothers and fathers of very young children.

The social justice theme of the 1980s and early 1990s is manifested in a continued stress on income-testing and on expanding child care services. In contrast to the 1940s and 1950s, when almost all FA were universal and even 1970 when less than 14 percent of FA were income tested, by 1976 one third were income-tested and more than half are now. There has been increased attention to lone-parent families beginning with the establishment in 1976 of the first means-tested benefit for these families.

Horizontal redistribution has been effective, but there has been no impact on the birthrate (except as alleged by those who insist that it would be still lower without FA). There is some evidence that the social justice achievements of FA have been offset by the reverse upward redistribution that occurs through the tax system; and the seeming conflict between the two has not been resolved. Many are convinced as well that policies regarding the easing of the tension between work and family life are still not adequate.

As to the value of FA, the basic benefit is by far the most important, accounting for almost half the FA expenditures and benefiting more than half of all families with children; in 1991 it was worth about 7 percent of an average production workers' wage to a family with two children aged 5 and 9. For single parents with two children, the benefit is worth more than 70 percent of average female wage and almost 60 percent for a mother with one child. Combining direct outlays and tax expenditures, family benefits constitute more than 4 percent of GDP. (In addition, of course, family policy includes expenditures for education, health care, and child care services.) And, as we shall see subsequently, the package for families with a still younger child is far more generous.

Child care services including preschool programs were initially seen as a social service for the poor and the vulnerable.[4] The first programs for very young children (under age 7) were charitable institutions established in the late 18th century under religious auspices, "to take care of deprived

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children of overburdened and sick mothers" (David and Lezine, 1975, p. 85). It was not until the 19th century that these facilities expanded throughout France and not until the mid twentieth century that they were transformed into the modern concept of a nursery school. The major growth in the *École Matèrnelle* has been since World War II, especially since 1955, with the growing participation of middle class children finally transforming the *Matèrnelle* into a truly universal institution, like the primary school.

The *École Matèrnelle* is a publicly financed program operated as an integral part of the French education system, under the Ministry of Education. The local facilities may be situated next to or in a primary school, but are often free-standing, completely separate structures.

Legislation enacted in 1976 provides the framework for the *École Matèrnelle* today. It stipulates that the *Matèrnelle* must "...contribute to the child's development ... in all its forms, physical, cognitive, and emotional. It trains the child in the use of different modes of expression and prepares the child for the formal education of primary school. It permits the early diagnosis and treatment of future learning problems and handicaps." (Felix, 1990, p. 54).

All children aged 2 - 6 are now guaranteed by law a right to a place in preschool. However, for the 2 year olds, for whom there are still not enough places, priority is assured to those from disadvantaged families and communities. At present, all 4 and 5 year olds, 99 percent of the 3 year olds, and about 40 percent of 2 year olds attend and the major focus is to expand the supply of places for the 2s (and to improve the quality) (INSEE, 1992). Over the past two decades increased enrollment of the 2 and 3 year olds has been the major accomplishment, since almost all 4 and 5 year olds were already enrolled in 1973-74, but only 72 percent of 3 year olds and 22 percent of 2 year olds were at that time. Although the program clearly provides child care to the children of working parents, it is obviously viewed as playing a much broader role, in particular, that of socialization, development, cognitive stimulation, and preparation for primary school.

The concept of the program is that it is an educational program, with the stress placed on cognitive development in the framework of a developmentally appropriate curriculum (Moss, 1988 and 1991).[5] The hours follow the pattern of the normal school day, generally 8:30 AM to 4:30 PM. Lunch is available at school, and many preschools (and primary schools) also have before-and-after-school programs as well.

The basic preschool program is free; parents pay income-related fees only for lunch and for the after-school program. On Wednesday, when French schools are closed (they are open for a half day on Saturdays), there are other special programs available. These, too are subsidized and available to parents on a modest fee-paying basis.

Although the French regard the *Matèrnelles* highly, group size and staff-child ratios would not satisfy American child development experts. Groups are large, as many as 25-30 children (or more) in a 4 year old group with one teacher (and sometimes, an assistant). Nonetheless, the programs are enormously popular and viewed as an essential socialization experience, whether to prepare children for school or to expose them to a valuable opportunity for peer play, growth, and development. French research (Baudelot, 1988; Kamerman and Kahn, 1981) has found that children who do not participate in these programs are likely to be disadvantaged when they begin school.[6]

POLICIES FOR THE UNDER 3s

Family policies targeted on children under age three began to emerge in the 1970s but developed primarily in the 1980s. The policies include: providing financial support for parenting; reducing the financial burden of child care costs for parents; increasing the public investment in - and the supply of - child care services (Hatchuel, 1989). As mentioned earlier, the first FA benefits targeted on very young children were enacted in the 1970s, when a child care allowance and a family allowance supplement were established for families with a child under 3. At the same time, child care services were expanded, first for the 2-6 year olds and then for the 0-3 year olds.

1. Maternity and Parenting Benefits[7]

Maternity leaves and benefits were enacted in 1946 and then extended to include adoption in 1976. Women who have been employed in covered employment for at least 10 months at the time of childbirth are eligible for a paid and job-protected leave covering 6 weeks before the expected birth and 10 weeks after a normal delivery. The post-childbirth leave is extended in the case of a casearean birth, multiple births, or a third or subsequent child. Cash maternity benefits are paid by the sickness insurance fund and replace about 84 percent of gross earnings up to a specified ceiling. (In practice, many employers compensate for the difference between the ceiling and the full wage.)

Medical and hospital expenses related to pregnancy, childbirth, and post-natal care are reimbursed to mothers who are either members of the social security system themselves or are married to members.

Parental Education (Child Rearing) Leave and Part-Time Work can be claimed by a parent who works for a firm with 100 or more employees and has been employed for at least one year at the time of maternity or adoption. Either parent is eligible for the leave, which can be claimed by one parent, or both, sequentially, at any time from the end of the maternity leave to the child's third birthday, or simultaneously, to permit both parents to work part time. Parents working for smaller firms may request the leave but it is subject to approval of the employer. During the leave, employees continue to be entitled to most work-related social benefits including credit toward pensions.

2. Family Allowances

A Young Child Allowance (APJE) was first established in 1985 and modified in 1987. A substitute for the earlier supplementary family allowance (for families with children under age 3) and the prenatal and postnatal allowances, it includes (a) a universal short term benefit covering nine months from the beginning of the fourth month of pregnancy through the month in which the child is born and three months after birth; and (b) a long term benefit that is income-tested and continues until the child is three years old. The benefit is awarded on a per child basis and the income ceiling is set so that almost 80 percent of all families with a child under age three qualify for the benefit including about 20 percent of all first children born in the late 1980s and about 38 percent of all second children. The benefit is contingent on the mother and child having had the required prenatal and post-natal medical examinations. The benefit was worth 11.5 percent of median wages and 13 percent of median female wage in 1989.

A Parental Education or Child Rearing allowance (APE), also established in 1985, is provided to a family unit for up to three years (until a child is age three) without regard to income. Eligibility is limited to a working family (one-parent, one earner, or two parents, two earners) with at least three children and one under age three, when a working parent who has worked at least two out of the last ten years, reduces employment by half or more after the end of the maternity leave.

The APE is intended to provide partial compensation for the loss of earnings following a parent's decision to take a leave from work and remain at home to care for a new (third or subsequent) baby. It is premised, in part, on the fact that most working mothers remain in the labor force after their first or second child is born, but find it hard to do so after the third child is born. Thus, those who have a third child experience a double financial burden, the extra costs of the baby and the loss of a wage. The benefit was worth about 40 percent of an average female wage in 1989 and may be supplemented by other family allowances for which the family qualifies, but not the APJE. It can also be paid at a 50 percent rate for one year for parents who chose to return to work part time when their child is age 2.

Two allowances (AGED and PSAM) were introduced in the 1980s to offset some of the costs of in-home child care for a child under the age of 3. The benefit is equal to the social insurance contributions a family must pay if they employ a caregiver for their very young child at home.

A child care tax credit is also available to working parents with a child under 6 to offset some of the costs of either in-home or out-of-home care. The credit is equal to 25 percent of the cost of care up to a limit of about $3,000 per child in 1990. This would mean a maximum tax credit of $750 for each child, per year.

The family benefit package for a family with two children aged 1 and 4 is not insignificant. The package includes the various special allowances for very young children, the allowances for all families with children, the income tax credits, and child care tax credits. The total annual value of the package as of 1990, in relation to median wages, is:

Husband/wife family, mother at home: 28.5 percent
Husband/wife family, mother in labor force: 22.4 percent
Single mother at home: 64 percent

Single mother in the labor force: 35.5 percent

3. Child Care Services

In contrast to the uniform system of preschool education for children aged 2 - 6, child care services for children under the age of 3 constitute an extraordinarily diversified and fragmented delivery system operated under the aegis of the Ministry of Health in the Ministry of Solidarity, Health, and Social Affairs. In addition to the *Écoles Matèrnelles* for the 2-3 year olds (under education auspices), they include:

- Crèches Collectives (day care centers serving 40 - 80 children)
- Mini-Crèches (small day care centers serving 12 - 15 children)
- Crèches Familiales (publicly paid and supervised family day care homes)
- Crèches Parentales (parent cooperative day care centers)
- Haltes-Garderies (Initially designed as occasional child care centers for the children of non-working mothers but now used largely for part-day care for children whose mothers work part time, or as supplementary care)
- Jardin D'Enfants (transitional child care for 2 - 4 year olds)
- Approved mother's helpers (privately paid but licensed family day care).

France has a long history of providing out-of-home child care, dating back to the practice of wet-nursing in the 18th century. *Crèches* were established originally, in the nineteenth century, as charitable institutions for poor children, with a primary aim of protecting against contagious diseases. Contemporary developments date from the close of World War II, with the increased investment in social protection generally. The *École Matèrnelle* expanded first, as a preschool program while care of the under 3s remained strongly linked to its initial health care orientation.

The most significant growth, however, occurred when legislation was first enacted in 1971 providing a substantial increase in funding for child care for the under 3s. Legislation in the mid-1970s imposed more rigorous regulations on *crèches* and stipulated that children were to be provided whatever care was necessary for their physical and mental development.

Still more significant growth occurred in the 1980s with dramatic increases in female labor force participation and a still greater commitment of national and local governments to expanding the supply of services. In 1982, the Secretary of State for Family Affairs announced that an early childhood policy was to be established with two objectives: (1) to reinforce the family and its daily living environment in its capacity to welcome the child; and (2) to implement permanent places of welcome outside of the family, in particular by providing early childhood education (child care services and preschool programs), and promoting health. In the mid 1980s two contractual mechanisms were established by the national government whereby the family allowance funds (CAF) would join with local government authorities, and, sometimes local voluntary agencies in providing funds to expand the supply of *crèches* and improve their quality. In addition, legislation enacted in 1977 (and newly projected improvements) provided special support and subsidies for regulated private family day care.

A philosophical change occurred as well in the 1980s leading to increased diversification and innovation in child care including the development of some programs verging more closely on family support services (and thus described below). This ideological change can best be described as a movement to change the term (and concept) of "care" in child care to "welcome" thus referring to "Places of Welcome for Children" rather than day care centers or nurseries. The *crèches* now began to be transformed from a health care service to a care and education program, from an institution that provided custodial care to one that provided a cultural and educational "welcome" and "awakening".

Crèches are group care facilities open to healthy children from 3 months to 3 years of age whose mothers are working. They are usually open from 7:00 am to 7:00 PM, Monday to Friday. *Crèches collectives*, the day care centers, are publicly financed, specially built facilities staffed by trained personnel, and operated under municipal or voluntary organization auspices. Although these are the most visible and most discussed form of care for the under 3s, they remain the least significant among the three major forms of care: day care centers, family day care homes, and preschool programs. There are also some private crèches under the auspices of voluntary agencies, religious institutions, or enterprises. Their function is the same as the *crèches collectives* and they are held to the same standards, licensed and regulated by government authorities. At the end of the 1980s, more than 80 percent of the *crèches collectives* were neighborhood-based, publicly funded, and administered by municipalities or local family allowance funds. Voluntary agencies are more likely to be operating *mini-crèches*. There are almost no for-profit programs. And the remaining *crèches* were located at or near parents' workplace, overwhelmingly hospitals (Felix, 1990). The average size of a *crèche* at the end of the 1980s was 47 places.

The costs for establishing a child care place in 1987 were 76,100 F ($12,660) for a place in a day care center. The costs for operation of a place in care in 1988, per day, were:

- 230 F ($39) in a *crèche collective*
- 228 F ($38) in a *mini crèche*
- 159 F ($27) in a *crèche familiale*
- 134 F ($22) in a *crèche parentale*.

In contrast, parents paid, on average, 60 F ($10) per day. Labor costs constitute about 80 percent of the operating costs of the first three categories of centers.

At the end of the 1980s about 60 percent of women with children under 3 were in the labor force: 54 percent were employed and 6 percent unemployed. Almost half of the under 3s (about 1 million) had working mothers and about half of these were in publicly subsidized care. About 13 percent were in the *École*s *Matèrnelles*, 8 percent in day care centers, 26 percent in regulated family day care ("approved mother's helpers"), and the remainder divided between informal family day care, mother's own care, and relative care. In contrast to the *Écoles Matèrnelles*, where immigrant children are as likely to attend as French children, the *crèches* are less likely to be used by children from immigrant families. Despite the fact that the fees are income related, they are also less likely to be used by low income families than middle class families.

In contrast, in 1970, with about 430,000 working mothers with children under age 3, France had child care places for about 250,000 children, as follows (David and Lezine, 1975): 19 percent in *Écoles Matèrnelles*; 6 percent in day care centers; 32 percent in regulated family day care homes. Assuming these data and our estimates of the current picture are correct, supply has increased dramatically during the intervening two decades, but demand has grown even more and the pattern of child care service delivery remains very similar.

A 1987/88 survey found that families were most satisfied with day care centers for the care of their very young children (77 percent), least satisfied with informal family day care (44 percent), and about equally satisfied with official family day care (67 percent) and relative care (62 percent). Given a wider range of choices, however, parents appear to prefer a longer, temporary leave from work (one year?) (Starzac and David, 1991; Hatchuel, 1989).

In the day care centers, staffing ratios are 1:5 for infants (babies who are not yet walking) and 1:8 for toddlers (Felix, 1990). In the part-day programs or those for children aged 2 - 4 (*Jardin d'Enfants*) the ratio is 1:20. Half of the caregiving staff must be trained pediatric nurses; and in larger centers, with places for 40 - 60 children, at least one qualified early childhood teacher must be present as well. Health and safety standards exist as well and appear to be enforced.

More than two-thirds of capital costs are provided by public authorities (local and regional government, family allowance funds). About half the operating costs of the centers are met by the local government, 20 percent by the CNAF (National Family Allowance Fund), 25 percent by parents' fees, which are subsidized and income-related, and the small remainder from a miscellany of sources.

To conclude this section, current child care trends in France continue to stress expanding the supply of places for the under 3s, with a first priority of assuring all 2 year olds a place (whether in the *matèrnelle* or *crèche*), but aiming for some kind of provision for the under 2s as well, not necessarily in full day care (see below). In addition to increasing the supply, there is growing emphasis on improving quality, focused especially on a new policy directed at developing cultural and artistic activities in the child care facilities, improving staff training, and reducing the size of centers. Finally, there is continued concern with supporting the goal of "choice" - and maintaining a "neutral" position as to whether mothers of very young children should be in paid employment or not.

4. Family Support Services

According to the most recent EC child care report (Moss, 1991), there is growing interest in France in encouraging greater diversity of childcare services, including the creation of multifunctional services, where a center may be used for several purposes, for example to provide full-time child care, a part-time play center, a place for parents to meet, a maternal and child health center, and a base for various other community services such as support for family day carers. In effect, the new philosophy regarding child care, extending its function from care and health in the 1970s, to care and education, and now to care, education, health care, and socialization has led to the development of new programs that are focused on mothers-parents-caregivers and children, not just on children themselves. The concept is of a place where very young children are welcomed by the society and are exposed to a wide variety of opportunities that will enhance their development; and that such efforts must include their mothers (if not their fathers) as well.

This new early childhood focus in France has led to a variety of developments at the interface of child care, health care, education, and family support. Part-day child care programs serving the very young children of non-working mothers are proliferating as are part-day mother/child programs that are designed to support both child development and parenting. Some maternal and child health clinics have established small child care programs within the clinic. Organizations established to work with immigrant children and their families have also entered the field.

Thus, for example, FAS (Fonds D'Action Sociale Pour Les Travailleurs Immigres et Leurs Familles) began in the mid 1980s to focus on very young immigrant children and their families from three perspectives: (1) Facilitating the progressive socialization of very young children from within the family to the school (preschool) system and the community at large; (2) Reducing the risks of conflict and tension between parents and children and between deprived immigrant families and the society at large; (3) Expanding opportunities for the socialization and development of these very young children through the establishment of community-based, child- and family-focused programs that would also link health care, education, social services, parent education.

These new "child and family support" programs have both child and parent goals. They focus first on helping inform and educate mothers/parents regarding appropriate child behavior, parent/child relationships and parent/child behavior by demonstrating for them what is appropriate. The child-oriented goals include helping the child separate from its mother (something that is often a problem for slightly older children entering preschool); helping the child integrate into a group of other children; preparing the child for preschool. The programs are "preventive" in the sense that they are designed to stress preschool-readiness and therefore to reduce the possibility of later school problems, to reduce the risk of child abuse and neglect, to reduce the risk of a mother's depression and isolation. The only requirements for the programs are that they be community-based, child-development centered, family-focused, and the child must be accompanied by an adult who cares for the child and who will remain at the facility while the child is there. The programs are all publicly financed but the funds may be supplemented by other resources.

Although many of the programs are deliberately established in poor and deprived communities, they are basically universal in their orientation. There is a growing conviction that the École Maternelle has been very successful because it is universal. Because it is closely linked to primary school, potential school problems can be identified early during the child's preschool experience and attended to. There is a new and growing conviction that one cannot wait until a child is 2 or 3 (when they enter preschool) in order to identify potential problems; nor can society limit attention to those under age 2 or 3 who have working mothers. Thus, societal responses must go beyond traditional child care.

The programs are not designed as a substitute for child care services but rather as a parallel and supplement. They are designed to provide more individualized attention and more flexible responses than the crèche, and to function as a bridge between the family and the larger society and the family and the École Maternelle.

Many of the programs were developed from the "Maisons Vertes" model of a flexible, neighborhood-based child and family program that was established by a child psychiatrist (later, social workers were active participants and advocates as well) in the late 1970s to help children and their mothers make the transition from home and family to school and community.[8] The concept was - and is - that many mothers, including those at home, find themselves physically and socially isolated after childbirth. Families are smaller, have fewer children, and if they have more children mothers may be overwhelmed. Children have fewer opportunities for socialization. These programs provide opportunities for children and their mothers for socialization, peer interaction, support, stimulation. The programs are part-day, part-week, include active parent involvement and two or more (depending on size) professional staff.

In contrast to the U.S. developments which emerged either from child welfare or crisis intervention services (Family Preservation Services) or early child development (Family Support Services) but focused on high risk families, these French developments stem from a concern with optimal child development and began in middle class communities. Recently, they have expanded to include programs for minority, immigrant, and other deprived families as well.

The French seem convinced that all children under 3 need a group experience whether or not their mothers work, just as children aged 3-6 do. They recognize that there is no consensus regarding the type of experience that is best for children or how extensive it should be. As a result they are encouraging the development of a variety of programs, including a range of formal child care centers and family day care, but now, also a diversified group of community-based parent/child centers. They stress the importance of supporting the cultural patterns and values of immigrants in these programs but do not support separate special programs for these children. Indeed, they characterize this latter approach as the "Anglo-American Model" and reject it strongly. Given the newness of the development and the deliberate effort at diversification, it is not surprising that there are no national data on the numbers of such programs, the numbers of children and parents participating, or, perhaps even more important, any evaluations - impact or outcome studies. These are discussed but not yet in place.

5. Maternal and Child Health Services

France has a universal national health insurance system dating from after World War II. The Maternal and Child Health services (PMI in French, MCH in English), which is separate from the health insurance system and administered under the Ministry of Health, began in France more than a century ago. MCH includes measures of both health and social protection. Current policies stem largely from the post World War II years.

Since 1945 free "well baby" or preventive health care has been available to children from birth to school entry, at age 6 through the MCH clinics.[9] This care includes monitoring growth and development, routine vaccinations, and advice to parents on the care, feeding, and development of their children. Visits are recommended once a month from birth to 6 months of age, every 3 months from 6 - 12 months of age, every 4 months from 1 -2 years of age, and then every 6 months until age 6 when the School health service (much less satisfactory according to all reports) takes over. There are seven mandatory prenatal examinations of the pregnant mother and three infant examinations (at one week after birth, 9 months, and 2 years of age) and payment of certain FA is contingent on documentation of these examinations. Relevant information is kept on each child's health record and a copy is sent to the appropriate MCH center to ensure necessary follow-up. Parents or caretakers may choose to have children examined either in a MCH center at no charge, or by their own private physician where they will pay but be reimbursed in all or part subsequently.

Since the early 1980s administration of the service has been decentralized to the departmental level, and as a consequence there is far more diversity and range in resource availability and allocation now than previously.

The clinics are community-based. The MCH team includes a doctor, a midwife, a nurse, social workers, psychologists. Although a universal service, it is used more by lower and working class populations. Of the 800,000 pregnancies each year, resulting in about 760,000 births, about 20 - 30 percent go to MCH clinics and the rest receive private care, which is covered under the French national health insurance program and is reimbursable. Immigrants and minorities make as much use of the MCH clinics as the native French population.

The MCH is a preventive service, not a treatment service, although the line of demarcation is sometimes crossed, especially in low-income communities. Home visits may be provided if deemed necessary, but not on a routine basis as in England and Denmark. Nurses play an important role in the decision whether to pay a home visit. Young mothers, those with large families, and immigrant mothers are the ones defined as at high risk and most likely to receive home visits.

Each pregnant woman receives a copy of a maternity record that includes all relevant information about her pregnancy as well as her legal rights and entitlements during pregnancy and after childbirth and information about resources for help, advice, child care, and financial support. Adolescents can come to the MCH clinic for contraception and receive advice and devices anonymously and free.

There is an important and close link between the crèches and the MCH through MCH's responsibility for inspecting and regulating the quality of the crèches and providing health care services to the facilities.

CONTEXT

1. Demography

France has a population of 57.4 million (1992) slightly smaller than Britain and a bit Italy, making it the third largest country in the EU. Along with Ireland, it has the largest proportion of children in the EU, with 20 percent of its population under 15 in 1992. Its aging population, at 14.4 percent, is only slightly smaller than that of Denmark (15.5 percent), Germany (15.3 percent), Italy (15.4 percent), and Britain (15.7 percent), all of whom have proportionately smaller child populations.

France has experienced extensive immigration over the past 30 years from its former colonies in southeast Asia and north Africa, and now from East Europe as well. France is one of the high immigration countries in Europe, with 5.5 percent of its population immigrant, and two-thirds of these from non-EC countries, the highest rate in the EC except for Germany. In a soft economy, immigration has been the scapegoat for many problems and the target of the radical right in politics.

At 4.7 per thousand population (1992), France, along with Greece and Ireland, has the lowest marriage rate in the EU, half that of the U.S. for the same year (9.4). Its divorce rate is also very low, however, not quite as low as Germany and nowhere near as low as Italy. Despite all efforts to do better, its total fertility rate (1991) is a bit below that of the U.S., U.K., Sweden, Norway, and Finland, and of course considerably below Ireland's rate. Out-of-wedlock births are at about the same rate as in the U.S. and Norway and slightly higher than in the U.K. but far lower than in Sweden and Denmark. Cohabitation is an important and growing phenomenon. Mother-only families, although a growing family type constitute only about 10 percent of families with children, far less than in the U.S., the Scandinavian countries, Britain and Germany.

In general, children have been a protected group in France. At the end of the 1980s, a senior French official stated that if you had children you would not be poor in France. Poverty was not a problem of children or families with children but rather of single individuals and childless couples. Nonetheless, when the first reports emerged concerning the characteristics of beneficiaries of the new (1988) French guaranteed minimum income program, RMI, it appeared that 37 percent of the recipients were families with children. Despite this, in a cross-national comparison of child poverty rates in eight advanced industrialized countries (U.S.H.R., Committee on Ways and Means, 1993), French child poverty rates (4.7 percent in 1979 and 4.6 percent in 1984) ranked 4th lowest, after Sweden, Netherlands, and West Germany, and way below the other four countries studied - U.S., U.K., Canada, and Australia.

Female labor force participation rates have increased dramatically in France over the last two decades just as they have in all the advanced industrialized countries. Indeed, they have continued to rise even in the face of rising unemployment rates. The rates for all women with children under 18 were 66 percent in 1988, and 85 percent for lone mothers (Sorrentino, 1990). The rates for women with children under age 3 were 60 percent, and 70 percent for lone mothers. These rates are higher than those for all the EC countries except Denmark, and are about the same as the other "medium-high" countries including U.S., Canada, and Norway. According to a recent French report (Felix, 1990), "The fact of becoming a mother leads less and less to the termination of employment for women. The tendency is rather to keep their job after childbirth..." French female labor force participation rates vary by the age and number of children:

72% of those women with one child under 3
76% of those women with one child aged 3-5
56% of those women with two children, the youngest under 3
67% of those women with two children, the youngest aged 3-5
27% of those women with three children, the youngest under 3
35% of those women with three children, the youngest aged 3-5.

Most women who work, work full time. About 22.5 percent work part time, a significant increase since 1980 and the major factor contributing to the dramatic rise in female labor force participation rates over the past decade, especially among the less skilled women. Most of the women who work part time are married, and the rates rise for those with two or more children.

Perhaps most important, when their youngest child becomes 3 and enters *École Matèrnelle*, women are increasingly likely to return to work. Those women who take a break earlier include some who prefer to remain at home caring for their baby - and can afford to - and some who cannot obtain child care. The women who interrupt work longer are the least skilled and educated.

2. Expenditures

Since World War II, France has consistently been among the countries which spend the highest proportion of GDP on social

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programs and among the leading countries with regard to real growth in social spending, as well. Only with regard to expenditures on education is France an "average" spender among the OECD countries, yet even in this area France spends more as a portion of social expenditures (SE) and GDP than the U.S., for example.

France was the top spender among the OECD countries on family benefits in 1960, 1975, 1980, and 1984, both in relation to GDP and in actual dollar equivalents. France entered the "golden years" of social expenditures (1960-1975) spending three times more than the OECD average, and despite the declining share of SE borne by family benefits, ended the "tough years" (1975-1985) with expenditures on family benefits that were two times the OECD average. With the inclusion of maternity/parenting benefits, in the post-1975 period, France remains a leader among the EC countries, sharing its position with Britain and Ireland. As mentioned earlier, French family allowances, maternity benefits, and tax benefits constituted more than 4 percent of GDP at the end of the 1980s. Moreover, France maintains its high ranking despite the fact that many valuable family-related benefits (*écoles matèrnelles, crèches*) are not included in either the OECD or EC data base, and thus do not show up in these tabulations.

When family tax and transfer payments are calculated as a portion of disposable income, France loses its top ranking but does remain among the top 25 percent of the OECD countries. One possible explanation for this shift in ranks is that some of its family benefits are targeted on families with children under age 3, while the "model" family used for the OECD analysis has no children this age in the family.

Two other aspects of the French situation are interesting: Despite the French population "anxiety", the elderly constitute the same share of the overall population as the OECD average and children constitute a far larger portion of the population than in almost all the other EC countries. Real wages grew more in France during the 1980s than among any of the other EC countries (although wages declined as a portion of GDP at the same time), and female wages became closer to male wages as well. Nonetheless, expenditures for family benefits did not keep pace with either pension or health expenditures, nor did their value keep pace with wages, nor did they maintain their share of family income. Compared to the situation of single persons, the situation of families with children generally, has declined.

But France did far better than almost all other OECD countries during the "tough years", and even more so if one took all family benefits into consideration, including child care and related services as well. Indeed, it is no wonder that France has been in the forefront among the EC countries in aiming for convergence of family benefits after 1992, with France setting the standard.

THE POLITICS OF SOCIAL AND FAMILY POLICY

France is an anomaly in modern welfare states. None of the several major studies of comparative welfare states have included

France.[10] And even when France is referred to it is often linked with Germany or Austria and the "corporatist" welfare states. Yet the French welfare state is clearly different. Among other things, family policy is a far more important component and France makes far more use of its family allowance system as a source of social protection for children and their families than do any of the other countries, with far greater success in sustaining child well being than most. How did this happen?

Ashford (1982, p. 233) refers to "the intricate pattern of political compromise and bargaining found throughout the French policy process..." as being the underlying theme in understanding French social policy, and adds that "By default rather than intent, France built one of the most complete social security structures in Europe." (p. 246)

First, the history of social policy and social security in France is more an outgrowth of nationalism than class conflict (as in Germany) or political pluralism (as in Britain). National social solidarity has been a constant theme in social policy debates in France.

Second, the initial developments following World War II, in establishing its social security system, were premised on the establishment of a system that would cover wage earners only (not a universal system), would be funded by employers primarily (two-thirds of the funding from employers, one-third by employees, and nothing from government), and thus would be free standing and independent of the state. This insistence on independence of government was, according to Ashford, the result of long standing mistrust of the state by the public at large and by employers. As a result, multiple interest groups had a vested interest in the development of social security as well as the social partners (labor, management, government) and the result was an incredibly complex system.

The concept and structure of the French social security system was drastically changed in the early 1970s, and France finally became a full-fledged welfare state. The initial concept of an autonomous and self-financing social security system was substantially modified and the future of social security was firmly attached to economic growth. National responsibility for social policy broadly defined was finally accepted. Some benefits were expanded beyond wage earners, and others were unlinked from employment status. Unfortunately, as Ashford points out, no sooner was the new structure accepted, then the first oil crisis occurred. However, once the system was placed under the control of the national government, the political appeal of providing more benefits led to more social benefits, more state subsidies, and more state intervention. As a result, the constraints of the oil crises did not slow France down for some time, and social protection continued to expand throughout the 1970s. However, following the 1974 legislation, the overburdened funds (pensions and health) were now permitted to borrow from the fund in surplus (family allowances) and as a result, FA were increasingly curtailed while the other benefit systems continued to expand. In fact, one other factor contributing to the growth in income-tested family benefits may have been the economic constraints imposed indirectly as a consequence of the growing burdens on the other branches of social protection.

Added to French nationalism was the strong Catholic tradition that stressed the central role of the family. This concern with the family is manifested even in the first post World War II decree which created the comprehensive social security system. In part, because of the existence of a separate family allowance fund, and in part because of the extensive array of "special" social insurance schemes outside of government and beyond the control of government, new social risks and needs (single parents, housing, orphans, prenatal care, maternity, child care) began to be responded to by the Family Allowance scheme, which was the only part of the social insurance system that was completely within government (although funded completely by employers' contributions of 9 percent of payroll).

ON THE GROUND

We describe below examples of the diversity of child care services on the ground in Paris and its suburbs, but not the full range. All are heavily subsidized.

1. Jardin d'Enfants Municipal

The *Jardin d'Enfants*, typically, is a "big city" form of child care and rarely seen outside of urban areas. This particular center is located in a middle class area that has begun to be gentrified over the past dozen years. The area still contains several immigrant neighborhoods, including one Asian community with Vietnamese, Cambodian, Indonesian, and Chinese families. About 10 percent of the children at the center are "immigrant" children including two black children whose fathers are from the Ivory Coast.

Both the *Jardin d'Enfants* (kindergarten) and the *Crèche* are operated by the local municipal government. Each has its own director and operates autonomously. The *Jardin d'Enfants* director is responsible for programmatic activities but she in turn (like the *Crèche* director) relates to the local government official responsible for early childhood education for budget and other administrative matters.

The *Jardin d'Enfants* serves sixty children, aged 2 - 4, in two groups of 30 children each. Staff include five educatrices (educators), two assistants who are puercultrices (a kind of pediatric nurse, with special training), one cook, two cleaning staff, and one director. All the children have working parents, either both parents, or their sole parent; this is a requirement for eligibility.

Although some children are accepted into the *Jardin d'Enfants* directly, others enter from the *crèche*, often the one next door. Some children, thus, will subsequently enter the neighborhood *école matèrnelle* directly from home, some from the *crèche*, and some from the *Jardin d'Enfants* (and, perhaps, earlier, a *crèche*). In general, it is believed that the children who have been in the *crèche* do better in the *Jardin d'Enfants*, and those who have been in the *Jardin d'Enfants* (or the *crèche*) do better in the *école matèrnelle*.

There is no one philosophy in the *Jardin d'Enfants*. Staff draw on various theoretical approaches to child development and child care, including some elements from Montessori and some from Froebel. They feel that the group experience is essential because it provides the children with opportunity for early and appropriate socialization and enhances their development. They believe that it is far preferable to care by nourrices ("nurses" or "nannies" whether at home or in family day care homes) because the staff are better trained and the program itself is more exposed and visible. By deliberate philosophy, children are closely linked to more than one staff member; but the staff are stable and children thus relate happily to several. The director, an exceptionally committed, experienced, articulate and well qualified woman insists on consistency for the children. Parents are expected to phone and let staff know if they are planning to take a child out early, or bring him late. Although not closed to parents, they feel that parents should inform them if they expect to come to the *Jardin d'Enfants* and observe an activity.

A very important component of the program is dealing with transitions, both transitions into the program and transitions out of it. This is an increasingly important issue for the école maternelle, and children without prior experience in separating from their mothers have more difficulty in the *école matèrnelle* (and later, as a result, more difficulty when they enter primary school). Stressing the experience of transitions in an especially supportive environment, it is argued, makes subsequent transitions easier for the children.

The director could not provide a budget for the facility since that is part of the responsibility of the municipal administrator, but she could state that the per day operating cost per child is somewhere between 217 and 250 FF. Of this amount, the lowest income parents pay about 4.5 FF a day and the highest income parents, earning over 24,000 FF per month (or almost $4,560 a month at the March 1992 exchange rate or about $55,000 a year), pay about 60 FF or $11.60 per child per day. Of this, the CNAF pays about 20 percent. The financial burden is therefore high for the municipality, but it is seen in the same context as the burden presented by primary school. Parents pay the fee to the director who sends it in to the municipal agency. Salaries and all vouchers and bills are paid by the same local government agency.

The sixty children in the *Jardin d'Enfants* are divided into two groups, each with two "educators", one assistant, and one "floating" educator. In effect, there are about thirty children in each group, with three to four staff plus two students. Each group of thirty children is subdivided into three to four groups of seven to ten children, who participate together in an activity.

Each group has one large room, two adjacent small rooms, and a washroom with child-sized toilets and sinks. There is also a kitchen that prepares meals for the *Jardin d'Enfants*. The large room is divided into three to four areas, each a center for different activities. It has the usual child-sized tables and chairs, a play house, a small stage with puppets. It also has a large closet that holds stacks of cots that are pulled out into the room after lunch, for the children to rest and nap.

The small rooms include one that is used for reading and quiet play, with low chairs and mats for the children to sit on while listening to stories. The second room is for finger painting and working with clay. It has low work tables and basins for washing up.

The children are encouraged to play with one another and to generate their own activities. But there are also teacher-initiated and led activities, depending on the time of the day.

At the entrance, there is a bulletin board that lists the menus for the week, and the major activities - all part of the policy of keeping parents informed. A more detailed activity plan for each group is listed on the bulletin board in the staff room, for staff to attend to when they are making plans for the next week or two. Among the activities listed are: painting; puzzles; making masks; playing with a kind of dough made from farina and salt (it is later baked and used with paper ornaments as sculpture, which is hung).

The first large room had a relaxed atmosphere with eight 2 and 3 year olds at two different tables and one adult at each table. At one table the children were fitting various kinds of pegs into boards and making designs of different colors and shapes. At the other table, children were crayoning and using magic markers.

In the second large room, eight children were at two tables with a "teacher" playing with a dough made of flour, grain, and salt, shaping it in different ways. At one table, the children were making masks. At another table, the children were making different forms with the dough, ranging from a bus ("like the one my papa drives"), to others who were making "sculptures". As they worked, the children discussed with one another what they were doing, what the other was doing, and they and the teacher talked as well. One boy came over from another part of the room and asked the teacher to unhook his suspenders so that he could go to the bathroom. A little girl left the table and went into the small adjacent reading room. She picked up a book and began turning pages. A friend joined her and they sat and looked at a book together, chatting to one another about the story. In a little while they returned to the tables and began to work on a figure modelled after a character in the book.

Several children arrived late, brought by a parent. After walking from one place to another, they joined an activity, either the mask-making table or the play-dough group. These were not "late" arrivals, but rather what might be called "second shift children". Depending on parents' work schedules, some children arrive as early as 7:30 in the morning but tend to leave at about 4:30 PM, whereas others may arrive a few hours later, but then will remain until the facility closes at 6:45.

The formal opening and closing hours are from 7:30 am to 6:45 PM, and most children who arrive early leave somewhat earlier, and vice versa. Children do, however, keep a regular schedule, except in unusual circumstances. Although most children are brought by their mothers, about one third are brought by fathers. Children, even the youngest (the 2 year-olds) seem to make an easy transition from parent to *Jardin d'Enfants*, and only one child appeared to have any difficulty with the transition that day; but not for long. Staff involved him in play and stayed close to him for a little while, until he settled in, happily joining another little boy in play.

The program is actually scheduled to begin at 8:30 but children may be brought at 7:30 if parents' work schedule requires this. One educator and the cook are present then. The children will be given breakfast if the parents wish it, and there will be free play until the larger part of the group arrives, at about 8:30. Since some staff will be staying late with the children who remain late, there are staged arrival times for staff between 7:30 and 10:00 am, and similarly phased departure times in the late afternoon. Thus, the various activities are scheduled accordingly.

The parents bring the child into his or her large group room, to the same educator each day, with the second staff member also someone who is familiar with the child and parent. It is only when all the children have arrived, been greeted and are in place that the doors to the other rooms are opened. From then on (about 9:00 or 9: 30) until noon, when they have lunch followed by a nap, the children can move freely from room to room. As the group phases down during the day, the numbers of rooms used and the number of activities are phased down as well.

In good weather, the children will go outside to play at about 10:00 am. Behind the building there is a large, rectangular play yard, with most of the ground covered by sand. There is a rope-net climbing toy, a jungle gym, a slide, and a variety of other typical playground equipment. There are also many used automobile tires scattered about. The play area for the *crèche* is adjacent, separated by a grassy area, but not fenced in. Near the end of the year, *crèche* children who will be transferring over to the *Jardin d'Enfants* in the fall may join *Jardin d'Enfants* children in outdoor play here.

Lunch is served at 11:30, with the food placed on one table in the large rooms, and the children coming to the table to serve themselves. The children select what they want from the foods that are prepared, choose the size of the portion they wish, the younger ones eating with a spoon and the older ones with a fork or spoon, depending on what is appropriate. They help in cleaning up when they are finished.

After lunch, the cots are put out by the assistant. While she does this, one educator helps the children who need assistance in going to the toilet or getting ready to nap. The other educator reads to the children, in the reading room, helping the children quiet down and preparing them for their naps.

The younger children all have the same spot every day for their beds, and the beds are numbered so they can be recognized. The older children's beds also have numbers, but the children tend to move them around a bit, so they can be near a special friend. There is also a basket of stuffed animals and other special objects which the children bring from home to sleep with. Most of them really do sleep during the rest period which lasts about two hours.

The children are relaxed in their play and active in their interaction with staff and other children. They call staff by their first names and the staff are clearly responsive to the children, and know each one very well. The director explained that she meets with each parent and child individually, before the program begins. She explains the program and the activities, talks to the child, and learns about the child from the parent. There is a group meeting in the fall before the school year begins, at which all the new parents meet each other and the educators for the group and are oriented to the program. After that, the contact is between the group leaders and the parents. Since most of the children are there for two years, the staff do get to know them all and their backgrounds. The students are there only for some months, however, dividing their time each year between the *crèche* and the *Jardin d'Enfants*, and therefore do not know the children as well.

Near the end of the academic year, children who will be coming over from the *crèche* will be invited to spend some time at the *Jardin d'Enfants*, to get to know the staff and the routine.

Similarly, children who will be going to the *école matèrnelle* in the fall, will have opportunities to visit there as well.

The children's medical records are kept on file in the director's office, in case there is need for contact. There is a psychological consultant who visits the *Jardin d'Enfants* two or three hours a week. If after some efforts to deal with problems that come up the staff think there is need for further consultation, they will refer an individual child for further help.

2. Crèche H_____

This is a *crèche collectif* or child care center in U.S. terms. It is housed in a building specifically constructed for this purpose, in the midst of an area that is both residential and commercial. The area is in the process of being gentrified, so the population is largely middle class, but still diversified. There are several North African children in the *crèche* as well as two Asian children, a black West Indian child, a Spanish child, and a Peruvian.

Although there is a large sign in front of the building saying "*crèche*", the building itself looks more like a three story office building than a child care center. The entrance is a large and impersonal "lobby", which has a *crèche* bulletin board with information for parents, and a large room off this that is used for carriages, strollers, equipment, etc.

The *crèche* itself is on two floors, serves seventy-seven children with about half of the children, aged 2 1/2 months to 18 months, on the second floor and the remainder, aged 18 months to

3 years, on the third floor. (The standard French paid and job-protected maternity leave ends ten weeks after birth. Although many working parents would continue to have an unpaid, job-protected leave available to them, some employers pressure women to return to work after the mandated leave, some return because they need their wages, some return because they want to for career reasons, and some return out of fear of greater vulnerability to lay-offs if they have been on leave for a long time.) Because of the staggered spring vacation schedule in the school system, a large group of children were absent, either taken away on a family vacation, or kept out for some other family activity involving older siblings.

The *crèche* is staffed with a director and associate director, both *puericultrices*, two educators (trained as early childhood education teachers), thirteen *auxillaires* (assistants or aides who have some pediatric nursing training but not as much as a *puericultrice*). The staff also includes a cook, a cook's assistant, two cleaning people, and a laundress. In effect, there are six or seven aides staffing each group of about thirty-five to thirty-eight children, plus one *educator* who both supervises the aides and plays a more specialized educational role in each group. The director and associate director are the overall supervisors, but also help out with the children in particular activities, when and if needed.

Staff are relatively stable. Although the work is not high status professionally and not exceptionally well paid, it is apparently adequate to recruit women and there are plenty who want such positions. In addition, when they leave, after four or five years of work as an aide, they usually go on to take more specialized studies, to become either a puericultrice or an educator.

The director explained that the *crèches* are operated under the aegis of the Ministry of Health (not education) and that earlier the program philosophy heavily stressed the medical and hygiene side of the care of young children. Now there is more interest in the educational and developmental components of a child care program. As a result, the director thinks that the staff, trained as nurses, all have some deficiencies in working with very young children. Their approach may be functional with the youngest babies who need a lot of physical care and attention with regard to feeding, changing, bathing, and so forth; but they are less effective with the toddlers. However, the health background does have some advantages. They do not reject children who have a cold, other types of respiratory inflections, even a low fever. If a child becomes slightly ill during the day, staff can cope and keep the child at the center, by putting the child to bed, to rest. If they think the child needs more attention, they will call the parent and suggest contacting the family's pediatrician.

A doctor comes to the *crèche* twice a week for two hours each time, checks to make sure the children all have the proper inoculations, sees children who the staff refer that day, checks for normal development or problems. If particular treatment is needed he/she will refer to the child's own pediatrician. Crèche doctors are not permitted to give prescriptions. Once in a while, if something serious happens (a child has a seizure, for example) they will take the child to the hospital and call the parents.

Despite their acceptance of mild illnesses among the children (or perhaps because of their expertise), the *crèche* has never experienced a serious disease epidemic since it opened. A few children have had the measles. There have been occasional occurrences of mild bronchial infections, but nothing serious.

The groups operate in much the same way throughout the crèche. Each group (assigned to one of the large rooms and two adjacent small rooms) has about twenty children with three aides (a fourth divides her time between the two groups with the babies). The *educator* divides her time between two groups, and there also may be student assistants as well.

Technically, there should be a staff:child ratio of 1:5 for the infants and 1:8 for the toddlers, and the actual ratios are about that or slightly better. However, in actual operation, the ratios shift with the different activities. Sometimes one staff member is actively involved in a one-to-one relationship with a child, and at other times several children are off playing by themselves, under the general supervision of an adult.

The cost for a child for a year is 48,500 FF ranging from 204.3 FF a day for space whether or not used, and 253 FF if a child is present (including the meals). The center is open all year (but not weekends) and staff vacations are staggered so that staff can have their full five-week paid vacation and appropriate days off, without undermining coverage. The actual cost is equal to about $9,120 and parents pay about 26 percent of costs averaging about 100 FF a day. The lowest-income families may pay as little as 4.5 FF a day (for a family with very low income and three children in the *crèche*). For a low-income family with one child in the *crèche* the fee would be 9 FF a day. The CNAF pays 33 percent of the costs and the city (Paris) about 42 percent of costs. For a family with two working parents earning over 24,000 FF, the fee would be 121 FF a day. Costs are fairly standardized from *crèche* to *crèche*. The only significant difference is the neighborhood and whether parents are largely low-income or higher-income, and therefore end up contributing a higher or lower proportion of the costs.

The *crèche* operates like a public agency. It has a line budget. The CNAF and city funds are allocated for specific purposes. The director is told which supply sources she can purchase items from, and is given vouchers to handle payment. The fees collected from the parents are paid to her and sent by her directly to the city agency, which in turn gives the director vouchers to pay for supplies. Salaries are paid directly by the city agency.

This *crèche*, like all child care facilities in France, including *crèches*, *Jardins d'Énfants*, and *écoles matèrnelles* is neighborhood-based and serves children who live nearby. There is a waiting list of 700! Although there are specified priorities for admission to the *crèche* (working parents, single parents, handicapped children) the director indicated that personal

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influence (knowing the right people in the city administration) often overrides other priorities; places in the *crèches* are very desirable and at a premium.

Parents and children approach their floor, by elevator, having left their stroller (if used) on the ground floor. Each floor has an outside play area or terrace, which is really roof space. A composition tile, made from discarded rubber tires, provides a safe outdoor surface. The *crèche* kitchen is located on the third floor.

The floor plan of the two floors is essentially the same. There is an entry room off the elevator, with cubbies for each child's outer clothing and change of clothes. Off the entry, are two large rooms each with two adjacent small rooms serving different functions on each floor. The pattern is for a parent to help a child remove her outer clothes and then to come into the appropriate large room and be greeted by a staff member. The child may then sit down next to that staff member, begin a free play activity, or join one of several special activity groups.

Downstairs, in the room for the infants and toddlers, four children were crawling on the floor of one of the large rooms, periodically stopping to play with various toys, also on the floor. Two babies were being held, one by a staff member in the large room and the other, a baby about 3 months old, was being fed by another staff member in one of the small rooms. We were told that this baby had difficulty holding food, came from a disturbed background, and was not fed by the mother before coming to the *crèche*. Eight children were on the floor, playing around one staff member who was also seated on the floor. Two others, slightly older, were on rocking horses. The room itself was colorfully decorated, with hangings, mobiles, posters, and a good deal of material that was made by children on this floor, or more often, on the floor above. Several of the children were dark-skinned. One of the teachers was black and another clearly Arabic. There was little tension in the group, no conflict of any sort, and very little effort to direct the way in which the children played with their various things. One was trying to roll a small toy car down a wooden ramp of a castle. Several of the children were playing by themselves, although a few seemed to be playing with one another.

There were a few cribs in the periphery of the big room, for later use, but one of the small rooms off the big room was also lined with cribs, for later nap time. The cribs in the big room were double-decker. The lower deck was on the floor level and the children would occasionally wander in, push the curtains aside, and lie down on the mattress, for a brief rest. There were moments when some of the children were out of the sight of any staff member, but nobody seemed to get hurt and the staff were clearly relaxed about it.

In another small room, water play was going on. One of the teachers was filling an inflated plastic pool with water and there were bottles, little rubber ducks, and other floating toys in the pool. Later in the morning three children were playing together in the water, completely nude. The teacher went out into the big room and asked if anyone else wanted to play in the water. Two others said they wanted to and were helped to undress and then joined the water play. There were plenty of towels and washcloths around. There were also two small plastic bathtubs and later two children sat and played in these as well. Before the day was over all the children would have had some opportunity for water play, and for bathing.

The water-play room and the crib room are the only rooms that are kept closed when not in use. All the other rooms, both the large room and the small rooms, are kept open and children wander in and out at will. Play in the water room is limited to certain times of the day, is closely supervised, and is carefully limited in the numbers of children playing there at any one time. The crib room is kept as a quiet, sleeping room, and used only at set times also. Babies who may take two or three naps a day may be placed in one of the cribs, following the child's usual pattern; and the room is kept quiet so sleep is not disturbed. The "older" toddlers who become tired at another time, go into one of the cribs in the large room, crawling or climbing on to a mattress and taking a rest.

The upper floor has the same basic room arrangements for those 18 months to 3 years of age. Before entering the large room there is space for an office for the director and the assistant director. The kitchen, serving both floors, is located on this level as well. All food is prepared by a cook and an assistant.

Here, too, in the entry room off the elevator and the stairs, the activity schedule for the week was posted so that director and staff could see what was planned for each group. The names of the staff, the activity, and the time and day of the week for the activity were posted. The activities listed include: collage, dancing, baking bread, making masks, painting, pasting, story-telling and reading.

On the stairway between the second and third floor posters were hung on the wall, for parents to see, explaining the program concepts and showing how children developed in the course of the experience. Pictures of children were used to illustrate the program's philosophy and in one instance there was the story of a Down's Syndrome child and how the program met that child's needs. The outside play area has a large sand box, a sanded area of the floor under swings, climbing equipment, slides.

In the upstairs large room for the older children, there are two large, low tables and child-sized chairs and several other "ateliers" (studios or workshops or in our terms, activity centers). What is the water play room downstairs is the finger painting room on this level. What is the crib room downstairs is a room for story-reading upstairs. When asked about the eighteen month dividing line for the two groups, the response is that it is not a hard and fast division but that the children do seem to behave differently at about eighteen months, and are ready for a differently focused program. Here, several of the children seemed more passive and less involved in the play (making a paste with rice, barley, grain, flour and water), often waiting for the staff to initiate an action; others were involved with baking bread. And still others were playing with small bicycles, kiddie cars, various types of cars and trucks, dolls, etc. When the dough had risen, the bread was baked, and later would be eaten.

In contrast to child care centers in some other countries, nowhere at the *Crèche* or later at the *Matèrnelle* and *Jardin d'Enfants*, was there mention of parent meetings, parent participation, parent involvement. Parents are interviewed when the children are admitted, are invited to a parent meeting when their child first enters the program, and are encouraged to talk with staff when they bring their child or pick him/her up. They are expected to stay at the center when their child initially enters the program, and they may visit during the day, if they discuss it first with the staff. Parent "power" and more active involvement are not encouraged.

Finally, despite the availability of the école maternelle when a child is 2 or 2 1/2, the typical child spends three years in the facility. When asked why, the response is that the longer hours, the greater flexibility of the program, and the higher staff: child ratios are more attractive to parents who pay very low fees, or can afford to pay the full cost.

3. École Matèrnelle O

This *Matèrnelle* is located in an industrial area not far from the airport that is regarded as an educational priority area. It serves children whose parents are industrial workers, some French and some immigrants. It is in a neighborhood surrounded by blocks of high-rise buildings inhabited by low-income families. These are the infamous Parisian suburban ghettos and slums that one reads about. Technically, school begins at 9:00. But in this neighborhood as in many others, parents' work day begins much earlier. As a result, children may come to school at 7:00 or 7:30, be given breakfast and then have an opportunity for supervised free play until the formal preschool program begins at 9:00. In those schools where there are not enough children to warrant a special early opening, children may be bussed to a shared facility at a *Halte Garderie* (a part-day preschool) where they are given breakfast and can play until it is time for them to be bussed back to their school for the regular program. There are special fees for this service but they are modest. The rest of the *Matèrnelle* program is free.

This *Matèrnelle* opens at 7:00 am and provides a halte garderie function for children in several nearby neighborhoods as well as its own. The building has five sides, surrounding a central courtyard that is a kind of out-of-door play area available for the youngest to play in, in addition to a yard which is used primarily by the 4-5 year olds.

The *Matèrnelle* serves 112 children aged 2 through 5. About sixty 4 and 5 year olds are in one wing and fifty-three 2-4 year olds in another. The total staff include four teachers (two male and two female), four cleaning women who serve also as meal servers and general helpers, four educators who supervise the before and after school free play times, a concierge and a handyman. All play active roles in the *Matèrnelle* program.

The entrance is an open area with the director's office immediately opposite, and the courtyard behind it. About twenty-five children were playing actively, running around, playing ball

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and climbing on a special construction. This free play continued from about 8:00 am (after breakfast) until 9:00, when one of the teachers blew a whistle and the children then dispersed to their various rooms.

To the right of the director's office is a room used for lunch for the 4-5 year olds. They sit at 6 adult sized tables, each with four chairs. Off this room is another similar room with child-sized tables and chairs, for the younger children. Beyond these two rooms are the group rooms for the 4 and 5 year olds.

To the left of the director's office is a hallway with a series of rooms in succession, looking like a traditional school building with high ceilings and dully painted walls. The walls had been decorated by staff with paintings, drawings, and posters that had been made by the children. Although the hallway was not very large, it played the role of the *piazza* in the Italian programs and underscored the importance of a central gathering, play area. Along the walls each child has a clothes hanging area which may also have a bag with other things. They keep their special T-shirts for water play, a smock, a change of clothes on their own hooks. Above each hook is a picture of a child and his/her name, so that the child can recognize his place. Further down the hall are racks for keeping kiddie cars and tricycles. And still further down, near the other end, is a large bulletin board where paper is tacked up for big paintings. Nearby there are low tables and chairs where the children can also work on their paintings.

The first room off this hall was a well-equipped, large room used for active physical play, containing slides, ropes to climb, climbing ladders, two jungle gyms a trampoline, a corner with very large blocks than can be used for construction, various blankets and cardboard boxes for active play. This room was used for the younger group in the morning but later in the day the older group played here since it was raining and outdoor play was not possible.

Beyond this is the "home room" for a group of twenty-five children; and after it another smaller room where cots are lined up with mattresses, blankets, each labelled with a child's name. This is where the children from this group nap or rest. Beyond this is the toilet and water play room for the group, with child sized toilets, two large sinks for washing up and water play, and an inflated plastic pool, also used for water play. Next to this is a quiet room which is used for music and dancing as well as reading and story telling. Beyond this is still another "home room" for twenty-five children, with its two satellite rooms.

Thus, in this cluster area there are about fifty children, divided into two groups of twenty-five each. However, they may be combined for some activities, and subdivided into at least two but often three or four subgroups for other activities. The exact boundaries of the division are not clear because children are not compelled to participate in any of the activities under way at certain times, and groups of two or three might be back doing things that they had done before or anticipating activities that will be done later. Each group includes a mix of 2, 3 and 4 year olds.

Parents bring their children to the school, help them remove their outer garments and put on whatever they will wear during the day, and bring the children into their "home room" (unless they are bringing them for the early breakfast and free play program, in which case they will then bring them back into the central entry room and part from them there). Here they will be greeted by the director who is also an educator for one group (along with a second teacher who is male). The teachers talk to the children, to the parents, and are actively involved in this initial activity.

During the arrival time some of the children who had been there earlier were already seated around one table eating corn flakes or bread and being helped by one of the cleaning ladies who serves as a general helper and was seated at the table with the children. Within about 40 minutes, about four groups of children sat down, had snacks, left the table, and were replaced by another group after the table had been cleaned up.

After they settled down, the first activity was to decide what they wanted to do for the morning "special" activity beginning at 9:30. One sign on the bulletin board indicated activities that would be led by Catherine, the director and teacher, (gymnastics and, later, water play) and others that would be led by Jean-Paul, the second teacher (music, then painting). The children had their names on cards in a little box and were expected to recognize their names and take their card and put it in the appropriate place to indicate which of the four activities they wanted to choose. The teachers spend a lot of time going from child to child to remind them to make a choice, explaining the choices, and sometimes helping a child find his/her name or place in the activity box. In some cases very young children recognized their names by the first letter: "I know it's my name because the letter looks like a snake!"

The posted schedule looked like this:

8:30 - 9:30 breakfast, free play, register (choose your activities for the next period).

9:30 - *ateliers* (workshops or activities): Drawing, music, water play, gymnastics (depending on the time and day).

10:30 - a second *atelier*, including another of the above four activities.

11:00 a special educational TV program, followed by singing - or outdoor play if the weather was good.

11:30 - 1:30 lunch and preparation for naps.

While the children played, changed their clothes, rode cars or tricycles up and down the hallway, Catherine got them to choose their next activity. The process was far more directive than in the *Jardin d'Enfants* or the *crèche*, where children were led indirectly, but almost never told what to do. The teachers talked to the children and to one another. The 3 and 4 year olds chattered to one another, to the teachers, and to themselves. A group of four 3 year olds were involved in animated and enjoyable talk over the telephones. A few children sat in a corner and were deeply involved in looking at books. Nearby, two little girls and one boy were equally involved in playing with a doll house. And behind that, three boys were sitting together working on a construction. Near the end of the corridor, a little girl anticipating the painting session already had her smock on and was standing with her roller, waiting for the paint. The cleaning lady continued serving breakfast. The maintenance man had two children in his arms and was helping others change their clothes. There was no quiet anywhere except around the table where the children were eating. One 2 year old was getting ready for gymnastics, putting her special outfit on and taking it off, repeatedly, with great skill in handling snaps. Eventually she went to her shoes, to change them, and had difficulty in putting them back on again, coming to Catherine for help. Two other 2 year olds were crying, either because they had found separation hard that day, or they were frustrated in trying to do something that an older child was doing. Two 4 year old girls came to their aid, before the teacher did.

Down the corridor, in Jean-Paul's room, children were choosing the right stickers to paste in spots under their name to show whether this would be a day that they were eating at home or at school. The maintenance man was helping two children change their clothes. Four boys were around a table constructing an enormous track by combining sections and building a very tall tower to go with it. Others were playing with puzzles and building with blocks. The free play tended to be gender-segregated, with boys and girls playing in single sex groups; but a few children also participated in gender-mixed groups.

Several of the children were black, Arabic, North African, or of some other foreign background. But most were French children, clearly of working class backgrounds.

At 9:30 the teachers announced that it was time to put everything away, and the children did so rapidly and efficiently. This is the pattern of the day. As each activity ends, the children are told that it's time to put things away, and they do so, with the help of teachers and helpers. After this, the children move into the more formal activities for which they have signed up. Those who would be painting got their smocks from their hooks in the hallway, collected small rollers, dipped them into the paint, and crossed the hall to paint on large sheets of paper tacked to the bulletin board.

At this point, the children were no longer with their own home room group but with whichever children had chosen that particular activity. Here and later in the day one had the sense of not enough adults to cope with so many children. Despite the participation of one of the cleaning ladies in helping some of the small ones put on smocks, and despite the active involvement of the maintenance man with the gymnastic group, and despite the help of a trainee, at many times children were either running wild without an adult nearby, or little ones were crying out of frustration, loneliness or whatever. It is not that they were ignored, but rather that they were not seen immediately.

One little boy cried almost the entire morning, only occasionally diverted into play. It was explained that he was among the few 2 year olds who had been admitted two months ago, in the middle of the year. He came for a few weeks and then was taken out while he went with his family for a vacation. Now they have returned and today was his first day back, his mother bringing him to school and then going off to work, leaving him to readjust on his own. He had a difficult day and there was no staff member who could take the time to give him the kind of individual attention he needed.

By about 9:45 all the announced activities were underway. Catherine led the gymnastic play, while also sort of supervising the water play, which was more directly led by an assistant with about six children. The gymnastic group involved about twelve children climbing rope ladders, jungle gyms, jumping on mats, etc. The children were daring, imaginative and curious; but nobody bothered to put the mats in the right spots and it seemed just luck that no one was hurt.

By this time the water play group had begun. The big plastic pool was full of water and children were pouring water back and forth with pails, funnels, and watering cans. There were no special themes or projects however, and the adults were not using the play and materials to enrich the children's experience and/or to provide links with other experiences, or to teach in a more formal sense about water, displacement, whatever.

Jean-Paul was more actively involved in helping the children who were painting, some on large sheets attached to the wall and others at small tables, with smaller sheets of paper. At the same time, in the sleeping room next to Jean-Paul's group room, four children - two boys and two girls - were sitting on the cork-covered floor, playing with tambourines, castanets, a recorder and a drum. They performed very much like a band, were having a marvelous time, needed no adult supervision. At one time, a fifth, a 2 year old who was much younger than the others, wandered into the room, stood alone and began to weep. Jean-Paul immediately went over to him, picked him up and talked with him for a few moments, brought him to another activity, and left him happily involved in play.

The director spoke of how proud the staff are because the *Matèrnelle* had been transformed from its previous mode, rigid and authoritarian, to one of flexibility and individualization. But it could also be described as a transformation from rigidity to chaos. Or perhaps not so much disorganization as two adults, almost one-armed paper hangers, trying to manage all kinds of individualized and diverse activities requiring costumes, materials, motivation, and explanation, with very little help except for the informal support of the cleaners and maintenance staff.

At 10:00 there was a change of activity and at 10:30 Catherine announced that it was time to put things away. She and the children cleared the various toys, supplies, etc away and by 10:45 the gym was orderly and empty, the bathroom was also empty and reasonably dry, and the hallway was strangely quiet. In the sleeping room, both teachers were leading all the children in a game, with the children seated in a circle. Then they sang songs and clearly had a good time. Several of the very youngest children were seated in the laps of the teachers and helpers.

At 11:00 the children went to the toilet, washed their hands, and dressed in their full outfits and clothes, ready to go outside to play. (In rainy weather, they would have a free play period instead.)

At 11:30 the children began to go into their respective eating rooms for lunch. On the wall was a list that said that there were seventy-four children registered that day for meals, twenty-one 4 year olds, twenty-two 3 year olds, and thirty-three 2 year olds. The menus showed full meals, including a hot main dish. Also posted on the wall were the holiday and Wednesday hours, because this school is a center for all kinds of after school programs.

FAMILY SUPPORT SERVICES

Family support services are increasing rapidly in France, especially in the large urban areas. And they are emerging under the aegis of different systems: child care; maternal and child health; social services. In some sense, *crèches parentales* (parent co-operative child care centers), not here described, offer a kind of family support plus child care service. Other programs are located in other systems.

The trend in France is toward the establishment of community-based programs serving very young children under age 3, and their parents. The focus is on both "welcoming" the child and "awakening" the child by stimulating his/her development in a variety of ways. The objectives are:

- to support parent/child interaction

- to reduce high risk and conflictual interfamilial parent/child situations;
- to refer those with special needs to appropriate resources;
- to facilitate adult/adult (mother/mother) as well as mother/child interaction.

The program concept was first launched in middle class communities but then moved to a focus on the more deprived. It is now expanding once again in middle class communities where it is viewed as an important strategy for all children under 3 whose mothers are not in the labor force, and who would otherwise not qualify for *crèches* or *halte garderies*. They are not designed as a substitute for *crèches* but rather as a complement and supplement. The overall objective is to enhance child development and parent/child relationships. Programs may be open five days a week, all day, or part day or even part week. Staff often include volunteers as well as paid staff. Thus far, despite the growing popularity of these programs, there has been no systematic evaluation of the extent to which they are achieving the desired goals.

The programs stress helping children learn how to separate from their parents, something that is often a barrier to the slightly older child's adjustment to the *Matèrnelle*. A second focus is on helping inform and educate mothers and parents regarding appropriate child development and behavior by demonstrating for them what is appropriate for 1 and 2 year olds. Inadequate parents are helped to become more adequate, to learn how to talk to and with their children, even to play with their children. Similarly, those parents who have difficulty with French are helped to recognize that this is not a unique experience for them, but rather an experience that is shared with many others. Third, they focus on reducing the social isolation of some of these mothers by placing them in a setting where they can develop relationships with other women in similar situations, through informal contacts.

The programs are designed as "preventive" in the sense that they are designed to stress school readiness, and therefore to reduce the potential for school problems, to stress educating and socializing mothers, to reduce the risk of child abuse, and to help mothers develop social networks, so as to reduce the risk of depression.

Basically, the only requirements are that the programs be community-based, child-development centered, and family-focused - the child must be accompanied by an adult who remains with the child while at the center. There is to be no formal registration or formal program or required activities. The programs focus primarily on children from about the age of 3-6 months to 3 years, and after school for the 3-4 year olds, and their mothers. They are all publicly financed but the funds are usually supplemented by other sources, whenever possible.

L'Arbre Bleu, one example of such a center, is located in the heart of the black and foreign ghetto area in the 18th arrondisement. Many old buildings near it are dilapidated, the streets are crowded and dirty. In the midst of all this is a clean, luxurious looking storefront with a logo on the glass window showing a tree. The setting is spectacular. An architecture firm that designs *crèches* and other children's facilities remodeled this storefront, that goes almost completely through the block, with a window wall at the back overlooking a garden that belongs to the houses behind it, in the next block. Clever construction resulted in a multi-level arrangement: there is a large sunken room in the back with sofas and chairs, attractively covered in a fabric with an African motif. To the right is a climbing and slide area, and a variety of niches which define other small activity areas. There is a very small kitchen, a small office, and bathroom, as well.

Most of the facility has the usual child play areas. The equipment is modern, colorful, beautiful. There are slides, stairs to climb on, a play house, child-sized table and chairs, and toys and books. It was just opened a few months ago and is not yet fully operational.

L'Arbre Bleu was created by a group of professionals: pediatricians, social workers, educators, who work with children and families in this and similar neighborhoods. The center was established with some funds from a foundation, the local municipality, and an advocacy organization for immigrant and deprived children to carry out the construction, purchase supplies, and pay the salaries of part-time staff. The objective is to provide an accessible, attractive resource for deprived parents and young children, or low-income foreign families in which the mothers have had limited formal education, to help prepare the children (and their mothers) for the *École Matèrnelle*.

The space is so limited however, that they were thinking of limiting the facility to parents and 3 year olds, but decided to include all those with children under age 3, after a new *Matèrnelle* opened in the neighborhood and was able to accept all the 3 year olds.

Since the mothers do not work, their children cannot go to the *crèche* or the *halte garderie*. The children are kept at home and have no direct early experience in French language, mores, or culture. They have been entering the *Matèrnelle* at age 4, with no ability to speak French; now they will enter at 3, but with the same problem. They come from Senegal, Mali, Tunisia, Morocco, and even the French West Indies. Even those from French-speaking areas have mothers who do not speak French, or do not speak it correctly. And most of the mothers are uneducated, and of course, unemployed. The function of these programs is to prepare mother and child for the later experience of the *Matèrnelle*, and thus to facilitate adaptation to the *Matèrnelle* and prevent problems of school failure when the children enter primary school.

The goal is to provide a kind of "soft socialization of the child", helping the child to make a "gentle" transition to group life without too drastic a break from the family. If the mothers are with the children in such a facility, so the theory goes, the transition is eased.

The program does not require any registration. Staff do not ask people's names and address children only by first names. The parents (overwhelmingly mothers) may come every day if they wish, or only occasionally, if preferred. The program is free. Mothers may sit and talk with one another but staff take no initiative about it, and no activities are planned or suggested. The concept is to get the mothers to accept and use the facility. To achieve this, staff follow the lead of the mothers. There are pencils, papers, and various supplies available and visible, for mothers and for children.

The mothers can talk among themselves and the children can play - alone or with other children - in much more space than they are likely to have in their crowded homes. A few families have already become regulars, but there is still only a maximum of fifteen mothers and children attending in what theoretically has room for twenty to twenty-five. Staff do not yet try to model appropriate behavior and mother/child interaction, as is done in some other similar programs because they are still experimenting with what would be effective and non-threatening. Thus far, only one father has come.

Staff are largely white, and speak only French, while the mothers by and large speak no French or very little. Nonetheless, they appear to communicate. Most of the children are toddlers (2-3 year olds); when babies are brought, staff bring out mattresses and put them in the sunken area where the mothers sit. Coffee is available but no other food, at least as yet. Staff are convinced that the program has value. There are other similar programs that have become very popular, and appear to be achieving the desired goals. It is too soon to assess this new, just opened center.

Still another form of family support service is the *Halte Jeu* at the maternal and child health clinic, described below.

MATERNAL AND CHILD HEALTH SERVICE

This maternal and child health service (MCH) is located in one of the poorest areas in Paris. The buildings are old and dilapidated, the streets in need of major repairs. It is a neighborhood of foreigners, recent immigrants, mostly black from Africa, and of high population density. There are two hospitals in the neighborhood, one public and one private, that provide maternity services and tend to channel cases to the MCH. There is also an *École Matèrnelle* and a *halte garderie*.

Staff include one *puericultrice*, a pediatric nurse, two aides (individuals with one year of *puericultrice* training), and a receptionist/typist. Of the three, one helps the doctor who is doing the examinations, one staffs the reception area, and one serves children in the waiting room with their families. The staff also share the housekeeping.

The doctor with whom we talked confirmed what we have encountered elsewhere. The program is supposed to be preventive, but for the people in this neighborhood it very often provides the only treatment they are likely to seek. Either they are not in the health system, do not know how to use it, or whatever. If they are without health insurance and something special is needed, they will be provided with a signed form to obtain the service at the local hospital; and the city will pay for it, even if they are illegal immigrants.

Most of the activity, however, is the mandatory health check ups at the specified times following childbirth. These check ups are essential, since they are preconditions for various child/family allowances. As indicated in the Carnet de Santé, the most important examinations are the ones at the week after childbirth, at 9 months, and at 24 months. A form must be filled out and submitted to the National Child Allowance Fund (CNAF). If not received at the CNAF, the allowance will not be paid.

The entrance is at the top of a flight of stairs, and at the beginning of the afternoon hours, parents and children assemble in the waiting room off the small reception room at the top of the stairs. Everything possible has been done to make the reception and waiting rooms attractive. There are posters, children's drawings, and health posters that explain such things as the importance of sleep and of good nutrition. There are toys in the waiting room for children of different ages, and children's books as well.

Outer clothes are left in the waiting room, and then parents and children return to the reception area where the children are weighed and measured. About five parents and their children were in the waiting room, including one father. All were black except for one Moslem woman and her baby. The black mothers chatted with their children while the Moslem mother remained impassive and silent. Three of the mothers had babies in their arms, and one was nursing her baby. Most of the children were toddlers, in animated conversation with their mothers or with the other children.

One of the aides engaged the children in play with the toys, in effect modeling for the parents what the children should be exposed to and how they can learn from play.

The doctor had an easy manner with the children and parents as he called them from the waiting room to go in with him to the examining room. He had the Carnet de Santé for each child, and the child's medical record with him. When they left, he handed both to the receptionist who filled them out and processed them properly, particularly the mandatory examination reports. The *puericultrice*, who is the administrator for this MCH, had previously worked at a *crèche* and a maternity ward of a hospital, so was well trained and experienced for this work.

The typical visit takes about 15 minutes, but the doctor is responsive to whatever may come up and whatever the mothers may bring up. A doctor sees about 15 children in one of his sessions. In the last quarter of the year, in this MCH, 1128 children were examined. There is some irregularity because the visits to the MCH reflect the times of birth, which are especially heavy in May, June, and July among the African families.

They serve children aged 0-6, and almost all the children in the neighborhood are seen by them. It is unusual for any to be missed. Mothers are told about the service in the hospital when they give birth, and by family and neighbors, subsequently.

Everyone uses the service. At age 6, the children are either transferred to a private physician or to the school doctor.

There is a heavy emphasis on advice, in addition to the check ups and inoculations: advice about nutrition, sleeping, developmental issues, and family planning. Contraception has become important here. The African pattern was breast-feeding for about 18 months to 2 years and no sexual activity during that time. Here they frequently resume sexual activity earlier and they have learned that contraception is important. The staff offer contraception advice, but for supplies they are referred to the family planning clinic for pills or other devices; or, if there is interest in what is called voluntary pregnancy interruption, they will be referred to the hospital.

The pregnant mother goes to a maternity clinic, or a hospital clinic or to a private physician, where there are seven compulsory visits as mentioned earlier. The CNAF knows that these visits have been made because the slips are sent in after the set of visits is completed. Once again, the allowance provides an added incentive for going for the prenatal check ups.

The biggest problem facing infants and toddlers in this neighborhood is the poor housing conditions of most families. The biggest medical problem is the related one of lead poisoning, which is much discussed here. There are no other large public health problems. The children are not hungry, but they do not eat a nutritious diet. Therefore something has to be done to educate the parents about food and diets. The fact that France has a housing allowance for low-income families with children does not solve the housing problem for these families, because first they must find acceptable housing to qualify. It is difficult to find such housing and there is prejudice. This is why many move to the suburbs. Some of the Africans have two or three wives and seven or eight children or even more. The landlords do not want to rent to them.

We noted the lack of overt coercion in relation to the Carnet de Santé, yet the reports of the mother's required prenatal visits and the infant check-ups that must be completed to ensure obtaining the special allowances. On the other hand, all of these documents promise confidentiality. When asked how this would affect an adopted child, the response was that a new Carnet is made up when the child is adopted, leaving out the information about the natural parents.

1. Family Support in an MCH Context

In contrast to the above, this would be described as a luxury setting. The center is housed in a beautifully built structure, where half is a *crèche* for 100 children. The entry is very attractive, freshly painted, well furnished, and well equipped. There are posters, children's paintings and other art work on the walls. This is one of four MCH's in this town which together serve about half of the children under age 3. The other children are seen either in other clinics which have pediatricians or in hospital emergency rooms, or, for the most part, by their personal pediatricians. Nonetheless, for some part of the population, the preferred service is the MCH, perhaps because it is free but perhaps because there really is a great deal of warmth and attention and it is located near home.

This MCH is staffed by one doctor who is there four times a week for examinations and services. This doctor is there on Monday evenings from 4:30 to 6:45 PM, on Tuesdays from 2:00 until 3:30 PM, on Wednesdays from 1:30 to 6:45 PM, and on Thursdays from 9:00 to 11:00 AM. The Monday and Wednesday hours are by appointment, and the hours on the other two days are unscheduled walk-ins.

An MCH visit costs 120 FF per child, and covers the staffing and ongoing expenses, not the capital investment; but is free to the families.

The doctor sees about fifteen children in each session, sometimes for the routine specified examinations, sometimes around problems or mothers' concerns. About 300 children are followed each year in this MCH. Of these, 100 are North African and 59 are black African, largely from Senegal or Mali. These are not the poor and marginalized families seen in the earlier MCH but rather families who have been in France for 15 or 20 years, and are now reasonably well socialized into French mores. They have steady jobs, legal work status, have obtained decent housing, and have learned what their entitlements are and how to use the system.

The director is a *puericultrice* and there are two other aides. At one point they used to have an *educator* as well who organized play groups. However, she was dropped because of the relatively small caseload carried here.

The information and advice provided parents by the puericultrice includes advice about feeding, nutrition, sleep patterns, and about what can be expected in general behavior at different ages.

In addition, this MCH has a spacious reception room and a very large waiting room with play areas that are designed to meet the needs of very young children of different ages. There are the usual toys, dolls, play houses, cribs for babies, a play pen, bookshelves, child sized tables and chairs, as well as access to an outdoor play area adjacent to the *crèche* playing area. At the end of the room is a scale and a place for measuring the children while they are being prepared for seeing the doctor.

The doctor has an examining room that has a small play area for the children as well. Here too there are toys and a cushioned floor area where the children can play, and one child sized table and chairs.

There is a small office for the aides, off the waiting room, so that they can answer the phone; and the director has her own office as well. There is a bathroom for staff and another for the mothers and children. And there is a small kitchen.

The half days and full days when there is no clinic here, staff have organized a free play group. Mothers come when the doctor is not here, to meet with other mothers, to bring their children to play with other children, to talk with the *puericultrice* and aides.

Numbers are limited for each session to about eight to ten mothers, who must give advance notice if they wish to use the program. Most of the mothers bring toddlers (1 - 2 year olds), and take advantage of the larger space and outdoor play area which they may not have access to from their own homes.

The main focus of the program is helping children learn how to separate from their mothers comfortably. In this community all children from age 2 and up are in the *Matèrnelle*. Making a satisfactory adjustment to the *Matèrnelle* is a critical step in the child's development and therefore anything that creates a barrier to facilitating that adjustment requires attention. Separation is an important issue for these young children, and for their parents.

Most of the mothers who bring their children are at home and not working, or at home on parental leave. They sometimes use the program as a drop-in service (while they take an exercise class or have their hair done) or as a place to meet with other mothers and children. They begin usually in the early fall, bringing their child in two or three times and staying with the child for the whole period. Then there are another two or three times when the mother will bring the child and wait outside, not completely leaving, accessible to the child yet separate, in another room. It is only after one or two months that the mothers actually leave the clinic, and leave their child there. Children may be left for a maximum of two-three hours at any one time, and not more than three times a week.

About seventy-seven children use the facility either in the morning or the afternoon. (It is closed from noon to 1:00 PM and lunch is not available.)

The director could not provide cost figures for this play group facility.

They have a special arrangement with the *crèche* for children who participate in the *Halte Jeu* (the play group) and with the *Matèrnelle.* Children from this program have their transition to the other programs aided by special visits made at the end of the year before the child will begin the *crèche* or *matèrnelle.*

Marital counseling and other types of family counseling are available here as well, as are social workers, who are present every Monday to respond to the needs and problems of their neighborhood caseload.

CONCLUSION

France may have been a late developer as a welfare state but it was a pioneer in its family policy beginning even before World War II. The peculiar complex structure of its social security system may have contributed albeit indirectly, to the extensive development of its family allowance system. A primary thrust of French family policy has been the implementation of an income strategy, including both cash benefits and tax benefits. A parallel, but secondary thrust has been a services strategy, focused on both maternal and child health services as well as child care and preschool education. A more balanced report of French family policy expenditures than that provided by the OECD might reveal the real extent of the balance between the two strategies. Nonetheless, it has clearly been a two-pronged strategy, albeit one dominated by an extensive, complicated, and generous system of income-transfers.

Family benefits in post-World War II France were established in the context of a commitment to social solidarity - to do better by families with children - and pronatalism - to increase the birth rate. Both of these goals have persisted throughout the intervening years even as others including social justice (vertical income redistribution), parental "choice" regarding family types, parenting roles, and balancing work and family life have been added. There is strong evidence that French family policy has been successful in achieving its primary goal - horizontal redistribution. France has not, however, succeeded in reversing the long-term down trend with regard to the birthrate; but there are some who would argue that the rate would have been even lower without these benefits. The social justice goal has been only partly achieved. There is some evidence indicating that the redistributional impacts of targeted family benefits have been offset by the upward redistribution that occurs through the tax system. Finally, there is continued debate as to the effectiveness of family benefits and related policies in easing women's burdens in balancing family and employment.

In the 1970s, public debate emerged for the first time about the relative weight to be placed on the goals of social justice and pronatalism. But with the left supporting vertical redistribution (to low-income families with children) and the right, horizontal (to better-off families with children), there was never any debate about whether or not more should be done for children and their families. The only question was how it should be done and how much should be done. By the end of the 1970s, FA had been transformed from a right of workers to a wage supplement, to a right of children to some minimum income.

In the 1980s, the decline in the birth rate renewed the right's interest in pronatalism, but social justice as a goal remained. Poverty emerged as a concern and the reconciliation of work and family life, especially for women, became a more visible issue.

In effect, when family policy goals were clear and consensual, as in the 1940s and 1950s, and both right and left were in strong support and agreement, family benefits rose in value, number, type of benefits, and in extent of coverage. When support from the right decreased, as in the 1960s, the value of the benefits in relation to other social benefits declined and no significant new benefits emerged. The "discovery" of poverty among families with children, especially large families and single-parent families stimulated new interest on the part of both the left and the right in the 1970s.

Family benefits cover only a small part of child-related costs, largely because the first child is still not covered by the basic FA scheme. But it is a significant benefit package, nonetheless, especially for single-mother families, low-income families with three or more children, and to a lesser extent, families with young children generally.

Although consensus is gone, the continued interest of both left and right in family benefits, even though the specifics vary, has made it possible for FA to remain a significant component of family income, of child and family protection, and of social policy generally despite some decline in value and importance as compared with other social benefits. As two French policy analysts have stated (Starzec and David, 1991), "The economic crisis since the end of the 1970s and the rise of unemployment during the 1980s have definitely had an effect on social policy as a whole, but have not called into question its underlying principles and priorities, including those concerned with family policy".

Finally, services for children and families have emerged as an increasingly important component in French family policy over the last two decades. The first significant post-World War II development was the maternal and child health service, second, especially in the 1960s and 1970s was the universal preschool program. Third, in the 1980s and 1990s is the *crèche*, and now the new programs offering a wider and more diverse "welcome" to the very youngest children and their families. Care socialization, development, school readiness are pervasive and recurrent themes, even among programs for the very young.

NOTES

1 See, for example, the various national plans issued at five year intervals from after World War II through the 1980s for a repeated discussion of family policy goals.

2 Michael S. Teitelbaum and Jay M. Winter, The Fear of Population Decline. Orlando, FL: Academic Press, 1985. However, the EC family observatory reporter for 1991 commented that the developing majority position is that the purpose is "assisting families to achieve their ambitions (rather) than attempting to modify their ambitions." This includes policy with regard to a third child. National Family Policies in EC Countries in 1991. European Community Family Observatory, Commission of the European Communities, Brussels, 1992, p. 17.

3 For a recent overview of French family allowances, in English, see, Marie-Gabrielle David and Christophe Starzac in Sheila B. Kamerman and Alfred J. Kahn, (eds.) Child Care, Parental Leave, and the Under 3s: Policy Innovation in Europe. Westport, CT: Auburn House, 1991, pp. 81-114.

4 For the early history of child care programs in France see Myriam David and Irene Lezine, Early Child Care in France. New York: Gordon and Breach, 1975.

5 For a discussion of French child care see also Martine Felix, Child Care and Equality of Opportunity in France, Report prepared for the EC Child Care Network, Commission of the European Communities: Brussels, 1990; and Peter Moss, Child Care and Equality of Opportunity, Consolidated report to the European Commission of the European Community. Luxembourg: EEC, 1988; and Moss, Childcare in the European Communities 1985-1990. Luxembourg: EEC, 1991.

6 Olga Baudelot, "Child Care in France" (1988). Paper presented at National Research Council/National Academy of Sciences, Committee on Child Development Research and Public Policy, Workshop on International Developments in Child care, Woods Hole, MA. Sheila B. Kamerman and Alfred J. Kahn, Child Care, Family Benefits and Working Parents. New York: Columbia University Press, 1981.

7 This section draws extensively on David and Starzac, op. cit.

8 For some discussion of the Maison Vertes model and its influence on family support programs in France, see: Les Lieux D'Accueil Parents/Enfants Dans Le Departement Du Rhone, Universite Lumiere-Lyon II, Institut Des Sciences et Pratiques D'Education et de Formation, 1990; Maisons Vertes, Dix Ans Après, Quel Avenir? Paris: Fondation de France, 1991.

9 For a description of this care see: M. Manciaux, C. Jestin, M. Fritz, and D. Bertrand, "Child Health Care Policy and Delivery in France", _Child Health in 1990: The United States Compared to Canada, England and Wales, France, the Netherlands, and Norway._ Supplement to _Pediatrics_, Vol. 86, No. 6, Part 2, December, 1990, pp. 1037-1044.

10 Neither the Peter Flora study, the earlier Flora and Alba study, nor the more recent Esping-Anderson study.

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SOCIAL POLICY AND THE UNDER-3S

THE CASE OF GERMANY

Table of Contents

PAGE

FAMILY POLICY AND THE UNDER 3S: AN OVERVIEW .... G 4

  1. Child Allowances and Tax Concessions .... G 8
  2. Parental Leaves .... G 11
  3. Infant-Toddler Care .... G 14
  4. Pension Credits for At-Home Care .... G 21
  5. Other Family Policy Components .... G 21

EXPENDITURES .... G 25

GUEST WORKERS, IMMIGRANTS, REFUGEES .... G 26

SOME FACTORS IN THE BACKGROUND .... G 30

  1. Demographic Trends .... G 30
  2. Mothers At Work .... G 33
  3. The Political Environment .... G 34

ON THE GROUND .... G 39

  1. Introduction .... G 39
  2. Child Care .... G 41
     The State of Hesse .... G 41
     Berlin .... G 53
     Kita Holtzmarkt, Berlin .... G 55
     A Center in Kreuzberg .... G 65
     Child Care in Schwerin .... G 74

CONCLUDING COMMENTS .... G 88

NOTES .... G 94

REFERENCES .... G 96

List of Tables

PAGE

Table FRG-1 West Germany Child Care Coverage Before Unification (1988) ....G 17x

Table FRG-2 Family Policy Expenditures Through Direct Payments and Tax Exemptions, 1989 ....G 26x

Table FRG-3 Foreign Workers in East and West Germany, 1959....................................G 28x

Table FRG-4 Origin of Immigrants to West Germany, 1950-1988......................................G 28x

Table FRG-5 Population and Vital Statistics in German States, 1988-1989................................G 30x

Table FRG-6 Female Labor Force Participation by Family Status and Presence and Age of Children, 1987.....G 33x

FAMILY POLICY AND THE UNDER 3S: AN OVERVIEW

While eschewing pro-natalism for obvious historical reasons, Germany has progressively developed family-related policies since the end of World War II.* It began with the elderly and soon was concerned as well with easing those financial burdens faced by families as a consequence of child rearing. In the years since the War's end, there have been shifts in emphasis as among policy instruments and in some of the policy specifics as government has moved back and forth between conservative and social democratic coalitions, but the idea of policies responsive to families is accepted by a national consensus. Moreover, while there is no one document that summarizes the family policy at any given moment, the statements of purpose in various statutory enactments, the foci chosen in the regular federal family and children's reports, parliamentary debates, ministry publications, and a considerable social science literature provide evidence that whereas (as would be the case in any pluralistic democracy) there is no one, fixed, monolithic family policy, the sum-total of enacted and implemented policies at any given moment does provide a reasonable picture of guiding principles, direction, intent.

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* NOTE: Although the formal re-unification of Germany had already been accomplished by the time of our study, the change process had only begun in the East, and the potential effects of the reunification on the total society and its policies were largely a matter of speculation. While we devote our "case" to the formal policies and operational realities of the Federal Republic before the wall came down, we have incorporated all relevant actual and projected enactments after that time. Returning to Germany in November, 1992, we have been able to discuss changing child care in the East "On the Ground".

With these caveats in mind, and focusing on families with children, it becomes possible to sum up.

German family policy, at its core, is designed to encourage and sustain the traditional, two-parent family with an "at home" mother caring for the children. At the beginning this always meant large families but now there is special interest in all those with two and three children as well; indeed such families are now considered to be "large". There also are components of policy responsive to gender equity and two-earner family concerns, and there is some sensitivity to the circumstances of single parent families, but these latter categories are not the main themes. For children whose families are disrupted or dysfunctional, there also is a clear social services structure and provision consistent with tendencies in most advanced industrial societies. However with regard to basic support and infrastructure, German family policy, especially in the past several years, has tended to concentrate particularly on the recognition of "family work" by mothers (and thus, indirectly, has special impact on the 0-3 age group).

The following, from the 1990 governmental Social Report captures recent formulations:

> The task of family policy is to create conditions that will facilitate the decision to add a child to the family and that will ease some of the cost of rearing and nurture. In order for this to happen, there has to be an equitable distribution of the burden of maintaining a family. In particular this means help for the young family, an acknowledgment of the rearing period in pension laws,

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> appropriate dwellings for families, agreeable surroundings for the children, along with the availability of volunteer family counselors. Beyond this, there must be measures to protect the life of unborn children. ... The federal government has committed itself to the task of removing the financial disadvantages of families with children as compared to those without.[1]

All of this is dependent, as well, on the basic social infrastructure of a modern welfare state. While in a listing of countries by political tendencies Germany in recent years has been at the conservative end, German conservatives have considered theirs to be a _social_ market. Modern social security, health insurance and educational policies characterize the social sector, and there is a basic safety net of assistance as well.

The principle of the social state, formulated in Germany's constitution, assigns to the legislature a mandate to "equalize social differences" so as to "ensure social security" and to create and maintain the "social security" of all citizens. While these are moral principles, not justiciable specifics, the following values are involved:

- respect and protection of human dignity, including an obligation to guarantee a minimum standard of living for all citizens in need;
- equality of all before the law and prohibition of discrimination on any basis;
- special state protection for marriage, the family, motherhood, and illegitimate children;
- freedom of association, in particular the right of workers to organize trade unions;
- private property and its social obligations[2]

How, then, do the family policies as described above manifest themselves?

We begin with a listing and, then, elaborate the major components somewhat. The starred items (*) constitute the core of Germany's under-3 policy, its "parenting" supports.

* - Universal child allowances (Kindergeld), with payments varied by the ordinal position and a lower payment tier for those at the upper levels of the income distribution. For all children, not the under-3s alone.

- Various forms of tax abatement for those who rear children, for single parents; a child care tax credit.

* - Full income replacement at one's salary level for a maternity leave of up to 6 weeks before childbirth and 8/12 weeks after childbirth, with costs shared between health insurance and the employer, and with all fringe benefit coverage continued without payment of contributions.

* - A 2-year period of income support at a flat rate (Erziehungsgeld) and a three-year job-protected leave (Erziehungsurlaub), as an extended benefit following childbirth, and income-tested from the seventh month at a level covering most births. Eligibility covers fathers and at-home mothers as well, in recognition of "family work".

- High rates of pre-school (Kindergarten) coverage (but with parental fees) for the 3-6s, but mostly in part-day programs.

* - Very little group infant-toddler care (Krippen) and family day care (Tagesmütter) for the 1s and 2s in the West, but very high Krippen coverage in the East, the latter in the process of some change.

* - Pension (social insurance) credit for mothers who rear children at home for a period.

- Health care coverage under a statutorily mandated insurance system, with 90 percent of the population included.
- The right for a working adult in a two worker family to remain at home for up to 10 days per year to care for each child under age 8 when ill. The single mother may remain at home for 20 days. (This was a 5 day entitlement before 1993.)
- A government child support guarantee for children in single-parent families if the non-custodial parent does not pay support (Unterhaltsvorschussgesetz) - but at a quite modest, income-tested level and inadequate for the not-employed single mother and time-limited (6 years).

1. Child Allowances and Tax Concessions

As do all industrial societies (the U.S. is the exception) Germany contributes to child rearing costs with regular child allowance (Kindergeld) payments. It has done so since 1955, gradually increasing the value of payments and the numbers of children covered (having begun with third children). Costs are met by government. In general, Social Democratic governments (SPD) tend to favor child allowances as well-targeted delivery to the low income families, while Christian Democratic governments (CDU) place heavier emphasis on child-conditioned tax concessions (somewhat more valuable to the middle class). Neither party completely ignores the alternative instrument. At present (with recent improvements) the monthly child allowance payments are as follows:[3]

1st child - DM 70 ($ 44.80)
2nd child - DM 130 ($ 83.20)
3rd child - DM 220 ($140.80)
4th child - DM 240 ($153.60)

The DM 420 monthly child allowance payment to a family with three children was equivalent to U.S. $3,226 annually in 1992. For higher income groups the payments are DM 70 for second children and DM 140 for subsequent children. The average one-salary, one-child, family with a wage earner had a supplement of 1.6 percent. The 3-child supplement was 9.5 percent of the average production worker's wage. Under the German pattern, in normal circumstances the payment is to the father (since this was originally conceived as a wage supplement).

Families whose incomes are below the tax threshold, and are thus not eligible for child tax exemption, receive a small monthly family allowance supplement of 65 DM per child.

In European Union context, converting all child allowances to the shared European ECU unit but not adjusting for purchasing power parities, Germany's family allowances (depending upon year and the child ordinal position), are among the more generous but not among the top three countries.

Calculations show that in recent years, considering child concessions in the tax code, the level of subsidy to parents below the tax threshold via child allowances and a small low-income supplement has been about equal to that provided families with typical family income through the combination of tax concessions and allowances, tax concessions having been recently improved at the same time as child allowances.

Further consideration of traditional family roles is found in income-splitting provisions in the tax code, which, while helpful when there are two earners with very different earning levels, are especially valuable to one-earner families. Two-earner families, on the other hand, do benefit from tax deductions for employing in-home help to care for children under 10 (or anyone needing full-time care so that the second family member may hold a job). There also are children's tax concessions associated with buying a home (Baukindergeld) in the tax code, valuable to those able to own their dwellings, but there also are rent allowances to help those of low incomes, whose standard rentals are excessive because of very low incomes.

To sum up: not specific to the under 3s, but helping their parents, too, child allowances and the tax concessions do offer basic economic underpinning to parenting in the form of income supplements (and, for the poor, social assistance). Of special interest, in 1990 the Federal Constitutional Court, ruling on a class action petition from tax payers who claimed that the deductions for child dependents were too low, supported the petitioners. The Court ruled, in effect, that if the social assistance grant is seen as a minimal maintenance standard for a child, parents not receiving social assistance had the right to similar basic help through tax concessions or child allowances. The government in 1991 raised child allowances and child-conditioned tax concessions to meet the Court's standard. While one may probe and dispute the calculations of the support minimum as equal to the social assistance grant for a child, the principle has apparently been accepted and the courts analyze consumption surveys in making their judgments. Other cases are waiting in the wings. A basic child-conditioned income guarantee may be developing and apparently would be consistent with constitutional philosophies.

2. Parental Leaves

The major, recent, family policy innovations in Germany came in 1986 with the Erziehungsgeld and Erziehungsurlaub supplements to the maternity legislation. These provisions accented the choice of an emphasis on families with very young children - especially two-parent families.

Under the pattern now in place, a mother may claim up to 14 weeks for maternity coverage, 6 weeks before childbirth and 8 weeks thereafter. The payment for maternity benefit is at the rate of DM 25 per day or DM 750 ($480) monthly, based on average earnings when last adjusted. If the mother's earnings were above DM 750, the employer makes up the difference. The job is protected. The not-employed mother receives a one-time lump sum payment of up to DM 150.

The new supplementary parenting leave and allowance is intended to encourage parental child rearing in the earliest years. The entitlement is extended to fathers and mothers. From the beginning the announced intent was to cover at least two years after childbirth, preferably three. There has been gradual extension from 10 months (1986) to 12 months (1988) to 15 months (1989) and then 18 months (July, 1990). Now a two year benefit (as of January 1, 1993) and a three year job-protected leave (as of January 1, 1992) have been phased in. The states are being urged to provide the income replacement for the third year and one, Baden-Württemberg, already has but has made modifications in eligibility requirements. The Rhineland will cover a third child and Berlin and Bavaria (Bayern) will provide the grant for an extra half year. As of this time there is little indication of similar action in other states.

The cash benefit is at a low level (DM 600 [$384] which was 19.3 percent of an average production worker's wage (female) or 13.6 percent of an average production worker's wage (male) in 1992). The flat rate for all holds for six months. Thereafter, the level of payment falls if income exceeds a specified threshold. Nonetheless, over 97 percent of eligible couples have claimed the benefit (92 percent of the eligible using the full 18 month period) and of these 82 percent were eligible for the full DM 600 after the first six months. (There was insufficient experience at this time of our study to know whether the "take up" for two or three full years would approximate the 18-month rate.) Some 10 percent get reduced benefits and only 8 percent of those who continue with the leave receive no cash benefits monthly because of the husband's salary. Given the traditional family roles and male-female wage differentials, few families assign the leave to the father (and of those who do, many have unemployed fathers).

The grant level is not enough to support a single parent family. The single mother has the choice of full-time work (a part-time wage would not be sufficient) or a public assistance application.

Also to be stressed is the fact that half of those who claim the benefit are housewives (a proportion consistent with labor force participation rates). These benefits have recognized what the German and Austrians call "family work". Not enough to be called a mother's or parent's wage, the Erziehungsgeld nonetheless is an attractive income supplement for two years after childbirth for the traditional family with one earner - or the two-earner family in which one salary is high enough for the other to remain at home.

Inevitably the question is raised as to whether Erziehungsgeld should not be indexed to the cost of living, or at least increased. In debate early in the fall of 1991, the point was stressed that Erziehungsgeld is not defined as a mother's wage or as a substitute for earned income. Rather, it was said, "it is an honorarium for motherhood". The practical debate was over whether the level should be increased or the duration. The latter position prevailed and it became a two-year benefit (January 1993). However, observers agree that eventually it will be necessary to increase the benefit level or to index it against inflation. This has not been feasible during the difficult economic circumstances of 1992-94.

3. Infant-Toddler Care

Within the recent decades, the Kindergartens for children ages 3,4,5 have changed from being regarded as undesirable intrusion into the familial responsibility for child rearing to a normative institution conceptualized as the initial (primary) stage of education.

In 1990, after some years of work and widespread private sector involvement, the two houses of the parliament passed a consolidated basic law on "child and youth services". The legislation affirms that "All children whose personal welfare requires support in day care establishments [elsewhere defined as including Kindergartens, nursery-schools (Krippen) or all day programs] ... shall receive appropriate help. The details of implementing this principle shall be specified by Land [state] law and the Laender [states] shall provide for adequate funds and facilities." (Act for the Reform ..., 1990, Section 24). This is interpreted as a strong "should" principle at the federal level but not a justiciable right. The states will determine their needs and capacities and some will create a legal right. (As of this writing, Sachsen, Sachsen-Anhalt and Thüringen, all in the East, have enacted the right.) In any case, most 3-5 children are now in Kindergartens, operated for the most part (with the help of considerable federal and state subsidies) by church-related and secular voluntary organizations.[4] A legislative guarantee of space for all 3-5s will be deferred until 2006 because of recent financial problems in Germany related to the unification and unemployment.

Thus, children now attend Kindergarten whether or not their mothers are away at work, and the programs reflect the mix of cognitive, developmental, and socialization concerns which characterize good early childhood education in most countries.

The responsibility for Kindergarten initiatives (monitoring, technical aid, federal policy) at the national level is with one of the three social ministries (Federal Ministry of Women's Affairs and Youth) which divide social policy portfolios. This ministry also deals with care for the under-3s. At the state level, where the real implementation responsibilities reside, the lead ministries are social welfare, or the equivalent (usually the Jugendamt, a child and youth office), or "labor and social affairs." In Bavaria administration is assigned to the education/ cultural affairs minister. Some cities (Frankfurt, Munich) have their Kindergarten and Krippen (for the under 3-s activities under education ministries. Krippen are all-day programs, usually 6 a.m. - 6 p.m., and are most often operated directly by municipalities since formally they are responsive to situations of "special need", not universal offerings, and thus in the Jugendamt purview. While as in the U.S. from the early 1980s and Italy and Britain in the 1990s, there is much discussion in what was West Germany of company-based child care, this type of coverage is thus far quantitatively insignificant. In the East, prior to reunification, a good portion of child care was enterprise based; but enterprise was the government vehicle for much social policy. Given all the closings and unemployment, there is currently no updated statistical estimate.

The states not only determine the scale on which they will implement child care programs;[5] they also (through the state level youth department, Jugendamt, usually) set staff qualifications and standards relating to hygienic practices, space per child, group size and general program parameters. Little is said in most western states about program content in the Krippen; however, (unlike the Kindergarten, under current philosophies) they are not formally conceived as having an "educational" mission. The five eastern states were in the midst of a major transition whose outcome could not at this point be foreseen at the time of our field work (see "On the Ground").

Coverage data are not complete, since there is a tendency to compare spaces with the size of the cohort - whereas some Kindergarten spaces are in fact used for under 3s. Nonetheless, in what was West Germany, the coverage was about 82 percent (1986) at last national count (perhaps 70 percent of the cohort), compared with 95 percent (1989) in the East.[6] Data for 1993 report 80 percent of the 3-5 cohort in Kindergarten. But there is another basic fact which conveys the policy: with the exception of 12 percent of the places (1986), the programs in the West are part-day, or half day. As the needs of working mothers have become more apparent and governments in some of the states (or leaders of the many voluntary organizations and churches which actually operate most of the programs) have become more responsive, earlier opening hours have become more common and more Kindergartens have gone from their 9 a.m. - 12 noon and 2:00 p.m. - 4:00 p.m. programs to longer days, but there still are few with "day care" hours, coinciding with the working day. By now many officials acknowledge the need and debate not the principle (which they once did) but the affordability. While recent expanded provision is not yet reflected in the reports, the fact remains that child care coverage for the 3-5s is still so poor as to block all-day work for mothers - who must be home for the noontime lunch in most cases. And even part-time work, in very short supply, is very difficult to manage. Given this picture, it is not a source of surprise that child care coverage for the under 3s in the West is almost non-existent.

We show, in Table FRG-1, the state by state under-3 coverage in the West as of 1986. Berlin and Hamburg account for half the places. Very little had changed in the interim.

[Table FRG-1]

If we add the 1.6 percent of the cohort for whom there were Krippen places in 1986 to the 1.5 percent in "official" family day care (Tagesmütter) places, the coverage was 3.1 percent. Use of micro-census data permits an estimate of "grey market" family day care - bringing the total to 4 - 5 percent. Now with the extended parental leaves covering 3 years, one should compute differently, not including year 1 of a child's life at all and including for year 2 some estimate of those whose parents do not use the leave. Nonetheless, the point remains: the combination of cash and leaves, on the one hand, and lack of Krippen places

Table FRG-1

West Germany Child Care Coverage Before Unification (1988)

State	Kindergarten Places	Coverage Rate Ages 3-5	Krippen Places	Coverage Ages 0-3
Schleswig-Holstein	39,346	53%+	401	0.6
Hamburg	20,169	55.8%	4,130	11.7
Niedersachsen	121,886	63.6%	1,841	1.0
Bremen	13,238	67.3	142	2.2
North Rhine-Westphalia	377,225	67.1%	1,816	?
Hesse	144,757	87.6%	2,240	1.4
Rhineland-Palatinate	110,698	96.0%	408	0.5
Bäden-Wüttemberg	308,936	97.9%	3,442	1.2
Bavaria	238,329	79.7%	3,004	?
Saar	29,181	95.7%	115	0.4
West Berlin	34,618	64.8%	10,814	21.1
Total	1,438,383	82.0%	28,353	1.5%

Source: Youth Welfare Statistics

for infants and toddlers, on the other, reflects a policy clearly supportive of at-home parental care by a mother (usually) who is not in the labor force or withdraws for several years.

Moreover, while much but not all of the delay in increasing the length of the Kindergarten day is said to be financial (many child care workers would need to be hired) the obstacle to the Krippen is very strongly ideological. The dominant political opinion considers it wrong for the infants and toddlers to be reared outside the home - and believes that the facilities provided should be those necessary to meet special needs (the poor, single parent families, foreign children). Reference is made in both the voluntary sector and government offices to a 1991 critique of international scientific research prepared at the Institute for Biology, Frieburg University, which concludes that the Krippe is an undesirable alternative to at-home child rearing.[7] Bensel makes his case by attacking inadequacies in published studies and asking whether Krippe children are happy or free of fear (topics not covered in most published studies). On the other hand, a leading Protestant organization in the children's field, in a review of competing assessments and ideologies, says that while home care is preferable, out-of-home organized under-3 care is essential. It should be of high quality and separate from Kindergarten. It can be on a smaller scale than Kindergarten coverage.[8]

In the East, the Kindergarten coverage was 95 percent, and all-day. Since mothers were at home on parenting leaves for a year, the Krippen coverage for the 1s and 2s was reported as 82 percent (or 56 percent if one included the 0-1s in the computation). In late 1991 and early 1992 there was speculation - and some political protest - about the insecure status of the Krippen in the East. After parliamentary inquiry and debate, the Government had been reassuring about the ability of the states to sustain capacity wanted and needed out of their block grants. (For the first 6 months there was a unique, direct subsidy). But the increase of female unemployment and the closing of many enterprises which provided part of the child care space and infrastructure left things uncertain. A major fall in birth rates in the five eastern states in 1990-1991 left excess capacity in some Krippen. Staff were attempting to avoid closings. The big unknown for the future is how closely the labor force participation rates for women in the East (over 84 percent) will in the future approximate the rates in the West (53 percent), - and whether the rates for married women with 1, 2, or 3 children (94, 91, 83 percent) will approximate the comparable rates in the West (47, 40, 35 percent). And how many will find it attractive to draw upon the Erziehungsgeld for two years? Informed officials expect East German mothers to remain at home for the entire period of the cash grant and therefore believe that the Krippen supply, while reduced by closings, should more than satisfy expected demand in the near future.

According to Tietze, Rossbach, and Ufermann, Krippen were everywhere in the West small. Half of all West German facilities reporting in 1986 had no more than 20 places and only 16 percent had over 40. Groups varied in size from 6 to 15 and most groups had 2 adults in charge. If one added all personnel known to be working in Krippen everywhere (not including management, maintenance, etc.) and related this number to the total child population, the ratio was 1:5 or 1:6.[9]

Of the personnel, as reported in 1988 national statistics for the West, 2 percent were college or university trained; 37 percent had the training for Kindergarten teachers, a 3-4 year technical course which follows completion of the 10th grade; almost 28 percent had the less-exacting training of care assistants, a 1-2 year course of practical training which follows the 9th grade; 20 percent were trained as hospital nurses and 10 percent were untrained or in training.[10] One cannot project the picture after unification.

The child care centers in East Germany were run either by government or enterprises in the period before unification. Now they are almost all government run, but the government is attempting to encourage the sectarian and non-sectarian organizations to take many of them over, as is the pattern in the West. In the West, in December, 1990, of 25,166 Kindergarten facilities, 7,770 were publicly run and 17,199 were private. Only 197 were workplace-based. Centers for the under-3s totaled 1,130 and were public (489), private (606) or company-based (35). Clearly there had been expansion from the 1986 count shown in Table G.1, which reports the most recently compiled national data.

4. Pension Credits for At-Home Care

Also in support of parental at-home child care is a policy enacted in 1986 which provides credit towards a pension (social security) for an at-home mother ("family work"), who cares for a child for a year. Now with the Erziehungsurlaub extended to three years, the mother may also, from 1992, earn up to three years of pension credit per child. Such credit is assigned at the rate of 75 percent of the average gross rate of all insured persons. At current rates, one "baby year" adds about DM 25 to the monthly pension. Five years of credit on this basis assures eligibility for a minimum pension. This benefit is of major value to mothers not in the workforce but also modestly supports workforce withdrawal for child rearing.

5. Other Family Policy Components

The other benefits and policies to be mentioned are not specific to the under-3s but are needed to complete the picture. The statutory health insurance system (sick funds) in Germany covers 90 percent of the population and preventive health care for children is included. Some places in Germany have retained the post-childbirth home visits by nurses or social workers. A system of routine visits and check ups at the family doctor's office, first for the pregnant woman and then for infants, toddlers, and preschoolers is specified, if not tightly monitored (9 "preventive" check-ups specific for children in the first 5 years, with about 80 percent compliance).[11] For historical reasons, school check-ups remain in the public domain. Children are examined physically and dentally by school doctors associated with the public health service before starting school, at age 10, and then in the 8th or 9th grade, at age 14 or 15. The uninsured, recent arrivals, the very poor have their medical coverage in the public health offices which are, otherwise, secondary to the private insurance system.

Health visiting and outreach are in the province of the states and are not now as common as they once were, obviously reflecting the significant insurance coverage in the private sector. In the state of Hesse, for example, health visiting ended about 15 years ago. One informant assumed it was the consequence of a new emphasis on insurance coverage and of the separation of the child/youth social service office from the public health department. State-level and local-level public health authorities carry the usual broad public health and environmental preventive and regulatory responsibilities but also provide other direct services to individuals if private doctors paid by medical insurance programs or voluntary organizations do not do so. This includes: maternity services; infant and toddler care; school health services; health counseling for the disabled; services to the mentally ill, the addicted, those with such infectious diseases as tuberculosis.

Of help to parents of all children under age 8 is a sickness insurance benefit, which permitted either working parent in a two-earner family to take up to 5 days (per child per year) until 1992, when this was increased to 10 days - so as to care for a sick child. Also enacted in 1992 was an amendment doubling the number of days for working single mothers, in a sense, allowing

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her to qualify for both the father time and the mother time of the two-worker family. Prior to reunification, the East Germany equivalent benefit was 20 days.

For single-mother families there is also the guarantee of child support when the non-custodial parent does not pay. The benefit, enacted in 1986, is a modest DM 291 ($186) per child per month, not means-tested, below the social assistance level and not enough to spare the single mother without a job the need to apply for social assistance. The low grant is justified by noting the principle that the non-custodial parent should be meeting half the support of the child.

This benefit was limited in West Germany to only 3 years of the child's first six years of life. It has recently been improved somewhat as it was integrated with an East German benefit covering children to age 18 (but with requirements for a court order or judgment, which kept eligibility low). The new benefit for all Germany will extend for six years and will cover children until age 12; the cost of the payment is shared equally by the federal government and the state. It will continue to be paid regardless of child or family incomes - and will remain at the relatively low level (about half of social assistance for a child if housing is not included). The benefit payment in the East is DM 219, a bit lower than in the West.

Mention also should be made of a modest "mother and child" fund, created in 1985, which allows discretionary benefits on a one-time basis. Although appropriations have doubled annually for five years, the average grant has declined from DM 700, because usage has also increased substantially. The grant is seen as an add-on to social assistance and provides funds for special things needed for a new-born. In some states, special institutes were set up to implement the legislation. In others, the grants are made through voluntary sector social agencies or abortion counseling programs. Some voluntary groups have refused to have anything to do with the program.[12] This "mother and child" grant was created to discourage abortion if the problems about bearing a child are an economic crisis.

Not relevant for the under 3s, but mentioned for completeness, is the fact that education in Germany is free, from the compulsory years beginning with age 6. Several years ago when Kindergarten completed its transition to a universal program defined as the primary stage in the educational experience, some educators tried unsuccessfully to "capture" age 5 for their system. The school day is a short one in the elementary grades (usually a half-day or less), and lunch is not provided even in those limited places where there are two hours of classwork in the afternoon. This poses a major problem for working mothers. The after-school child care facilities, the Horte, are organized much like the Kindergartens and had coverage in the West for about 4 percent of their cohort in 1990 (82 percent coverage in the East).

After four years of elementary school, German children move into a three-track system based on ability and leading ultimately to full university training, an occupational/ apprenticeship option, or a middle level of secondary training. There is a related system of federal and state financial grants and loans for those over age 16, specific to the "track" chosen and to the family income level.

EXPENDITURES

In our review for the 1960-1985 period of government expenditures for children and their families in advanced industrial societies,[13] Germany was seen as a country with higher governmental expenditures and higher social expenditures (as a percentage of GDP) than the OECD average. By 1990 and 1991 Germany was a bit below the average on government expenditures and a bit above on social expenditures.[14] However, it should be noted that for the 1960-1985 period, Germany was consistently above the OECD coverage in social expenditures as a percent of government expenditure, although it was rather close to the average in the later years. On the crucial question for our purposes of family-related transfers for children, Germany was well below the OECD norm in the 1960s and 1970s, but had leaped beyond the OECD average in 1980, only to fall back somewhat by 1984 (in constant 1980 prices and purchasing power parities dollars). Similar trends are seen with regard to the family benefit share in GDP, where Germany remains below average.[15]

Some caveats are here necessary. These comparative data do not include tax expenditures generally and they omit health and education data. With regard to health expenditures, with child data not disaggregated, Germany has been one of the top-spending countries. In education, it remained below the OECD average in share of GDP, but not very far below. Inevitably, too, these are central government comparisons: since child care is largely a function of the states, international comparisons are not readily available.

All of this should be seen in a context in which over recent decades the social program shares assigned to pensions and health have been growing while the shares for family benefits and education have declined - the former more than demographic growth (the elderly) and the latter more than the demographic decline (the child proportion in the population). Available data or analyses do not permit full assessment of Germany's relative status in family expenditures for 1985-1990; it will take several years before the full impact of reunification can be analyzed.

For the moment the questions arise as to whether recent increases in child allowances and tax concessions (modest but not insignificant), the considerable growth of Erziehungsgeld, and the expenditures at the Land (state) level for Kindergarten and Krippen will change the comparative picture. As seen in Table FRG-2, expenditures that can be reported are not insignificant.

GUEST WORKERS, IMMIGRANTS, REFUGEES

The topic is relevant to the "under 3" exploration in two ways. First, when experience in other countries is discussed, Americans ask whether their development of programs and policies faces the complexity we face because of the size and large numbers of minority groups in this country. Second, if countries

G26x

Table FRG-2

Family Policy Expenditures Through Direct Payments and Tax Exemptions, 1989 (DM Millions)

Tax free allowance Kinderfreibetrag:	7,900
Other family-related tax reductions Andere familienbezogene Steueremäβigugen:	4,485
Child-care benefit Erziehungsgeld:	4,000
Consideration of child-care time in the pension Kindererziehungszeiten in der Rente:	2,990
Children's allowance and Children's allowance supplement	14,100
Training allowance Federal Part Ausbildungsförderung Bundesanteil:	1,520
Federal Foundation "Mother and Child" Bundesstiftung "Mutter und Kind":	130
Maintenance Advance Federal Part Unterhaltsvorschuβ Bundesanteil:	96
Married couple tax splitting Ehegattensplitting:	25,700
Total	60,921
Money Transfers Geldleistungen:	22,836
Tax allowances Steuerbereich:	38,085

Source: Federal Ministry of Youth, Family, Women and Health, Materials on Family Policy (Bonn, 1989).

have coped with "foreigners" successfully, does their experience offer useful lessons for the United States?

For Germany, our "short" answer must be that the timing of the study makes the exploration somewhat unprofitable. We offer a brief explanation here and add some further comments below in the context of the child care descriptions.

Germany - like most of Europe - has not been an immigration country in the U.S. sense. Its 1989 population of foreigners was 5 million (8 percent) before the recent uncontrolled refugee surge began. The U.S. question, by contrast, is only in what immigrant cohort one's family history begins. Germans, as many Europeans, tend to think of all those whose original nationality is not German as "foreigners", whenever their arrival. It is difficult, in fact close to impossible, to become a citizen.[16] In most recent years, of course (and not shown in the table), these have included many thousands of Europeans, Asians, and Africans asking for political asylum as political refugees, economic refugees, and illegal immigrants from the formerly Communist East and central European countries and the earlier "imported" guest workers, 1.7 million in the West, and about 95,000 (the largest group, 60,000, is the Vietnamese) in the East. Of the former, many are now second generation and some are third. Not included in these totals are the recent 200,000 refugees from the civil wars in what was Yugoslavia and the resettled "non-foreign ethnic Germans", the largest group of all. Some of the latter were scattered by the U.S.S.R. from the eighteenth century Volga German enclave. Others have long lost their links with German language and culture as historical boundaries changed.

[See Tables FRG-3 and FRG-4]

Thus there is little doubt that in the years ahead German policies and programs will be well tested in their capacity to deal with and respond to diversity. However, the family policy and infrastructure here reviewed were developed when the largest "foreign" element identified was the Turkish and Yugoslav guest-worker community, especially the former. These were regarded as "temporary" residents and, indeed, a significant number were provided incentives to leave when the economic situation early in the 1980s caused many to be regarded as surplus workers. Policy development for families with young children did not have them in mind. Now, those who remain (and their numbers are significant, if proportionately small on a U.S. scale) are more visible as apparently permanent residents in a number of cities and they have full rights to benefits and services. Thus we have been able to ask about "Turkish" (or, in the U.S. style, Turkish-German) children in Krippen and Kindergarten. However, it must be noted that while the programs and polices did evolve for a "German" population with a small guest worker subset, not for a large "minority" population, the growing "foreign" representations, the higher guest worker fertility rates and the low German fertility meant that significant numbers of the children being born when Erziehungsgeld was enacted and the Kindergarten explosion took place in the 1980s were, in fact, children of guest workers and other foreigners. The post-

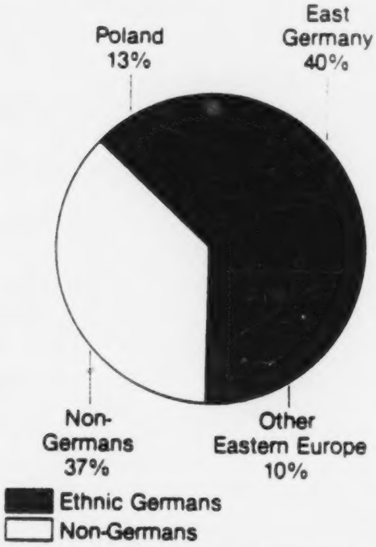
Tables FRG-3 and FRG-4

Table 5. Foreign Workers in East and West Germany, 1989

Country of origin	Foreign workers (in thousands)
East Germany	
Poland	7.0
Vietnam	60.0
Mozambique	16.0
Angola	1.0
Cuba	9.0
China	1.0
North Korea	0.6
Total	94.6
West Germany	
European Community	497.3
Italy	178.9
Greece	101.7
Spain	61.6
France	41.3
UK	36.5
Other	77.3
Rest of Europe	1.023.4
Turkey	561.8
Yugoslavia	300.9
Austria	88.7
Poland	25.4
Czechoslovakia	11.6
Other	35.0
Africa	40.4
Americas	34.8
Asia	73.7
Other	19.7
Total	1.689.3

Source: Official published statistics.

Figure 9. Origin of Immigrants to West Germany, 1950–1988



Total net immigration = 7,883,000

Sources: See Table 4

Source: Helig, Büttner, and Lutz, 1990, p. 26.

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unification picture cannot yet be sketched because it includes the several migrations mentioned above, as well, but clearly this will test the family policies.

Currently, for the ethnic Germans there is a financial compensation program (compensation for what was left behind), with some social service supports as well. The problems derive from the scale of the movement and housing shortages, but there is no issue about access to the system. Refugees, in the long period during which their status is being determined, have access to what Americans (and indeed unemployed East Germans) would define as generous social assistance allowances for food, shelter, clothes - even though they are not permitted legally to work. (Some 256,000 arrived in 1991, over 165,000 in 1990 and almost 450,000 in 1992 and the processing was so slow as to be the subject of a national and international outcry and demand for reform.) If turned down but unable to go elsewhere, they receive humanitarian aid and may be allowed to work. The legal and the illegal immigrants and settled guest workers, once employed, have entry to the universal supports of health insurance, unemployment insurance, and the child policy measures already described, including Kindergeld and the parental allowances and leaves. Then the issue becomes what and how they preserve by way of ethnic traditions and what problems they and their school-age children have in integrating into the mainstream. In some areas of large cities they constitute significant portions of the population; in some small cities their numbers are small but they are concentrated. One cannot at this point predict the consequences of the outbursts against and attacks on refugees at many locations, mostly in the East, in 1992 and 1993 - or of the legislative and administrative changes affecting refugees and immigrants subsequently enacted.

It is estimated by government officials and scholars that whereas some 90 percent of the "German" 3-5s currently attend Kindergarten, only 50 percent of Turkish and other Moslem children do. (1986 data report preschool registration of 57.3 percent of the "foreign" 3-6 year olds). In fact, school non-registration, absence, and drop out has been a problem, especially where there is parental objection to cultural assimilation by their daughters. This is said to be a problem that is decreasing.

SOME FACTORS IN THE BACKGROUND

In this section we draw together some of the context for the enactment and implementation of the policies sketched. The "foreigners" discussion was dealt with separately because it was probably less of an influence in the past than it will be in the future.

1. Demographic Trends

Appendix Table A-3, for 1990, places Germany population statistics in European context and includes all other countries in the study. Table FRG-5 covers the former western and eastern states in the reunified Germany and sums up for 1989.[17]

Without repeating the country-specific data in the tables, we might generalize with regard to German families by noting that

Table FRG-5

Table 2. Population and Vital Rates in German States, 1988–1989

Federal state	1989 population (thousands)	Population density per km2[a]	Birth rate (per 1,000 population)	Death rate (per 1,000 population)	Natural increase (percent/year)	Infant mortality rate[b]	Life expectancy at birth[c] Male	Life expectancy at birth[c] Female	Total fertility rate[d]
Bavaria	11,221	159	11.5	11.0	+0.5	6.8	70.9	77.4	1.5**
Lower Saxony	7,238	153	10.6	11.7	−1.0	7.5	70.7	77.4	1.4**
Baden-Württemberg	9,619	269	11.7	9.9	+1.8	6.7	71.8	78.1	1.4*
North Rhine-Westphalia	17,104	502	11.0	11.2	−0.2	8.2	71.8	78.4	1.4**
Brandenburg (GDR)	2,641	91	12.4	11.8	+0.6	7.7**	69.4	75.1	1.7
Mecklenburg-Vorpommern (GDR)	1,964	82	13.4	10.7	+2.6	6.7**	68.2	75.2	1.9
Hesse	5,661	268	10.5	11.2	−0.7	7.4	72.6	78.8	1.6**
Saxony-Anhalt (GDR)	2,965	145	11.7	12.7	−1.0	8.2**	69.2	75.2	1.6
Rhineland-Palatinate	3,702	186	10.8	11.6	−0.8	7.7	70.4	77.1	1.4**
Saxony (GDR)	4,901	267	11.2	13.6	−2.4	6.8**	70.5	75.9	1.6
Schleswig-Holstein	2,595	165	10.6	11.9	−1.2	6.7	71.0	77.4	1.5**
Thuringia (GDR)	2,684	165	11.7	12.6	−0.7	9.0**	69.7	75.6	1.5
Saarland	1,065	414	10.1	11.7	−1.6	9.7	69.2	76.2	1.3
Hamburg	1,626	2,154	9.5	13.2	−3.6	8.0	70.5	77.3	1.3
Bremen	674	1,668	9.8	12.7	−2.9	5.8	69.9	77.3	1.2*
East Berlin	1,279	3,174	13.2	10.4	+2.8	7.6	70.2	75.3	1.5
West Berlin	2,131	4,436	10.1	14.4	−4.3	8.6	68.6	75.8	1.4*
Total Berlin	3,410	3,862	11.2	12.7	−1.6	8.1**	-	-	1.5
East	16,434	152	12.0	12.4	−0.4	7.6	69.6	75.5	1.6
West	62,636	252	11.0	11.3	−0.3	7.5	71.8	78.4	1.4
Germany	79,070	222	11.1	11.4	−0.3	7.5**	71.3	77.8	1.5

* 1986 data **1988 data

Source: Central Statistical Office, Wiesbaden; individual statistical bureaus for West German states; estimates for former East German districts were based on official statistics that will be subject to revision under a unified statistical system.

[a] 1 square kilometer = 0.61 square miles
[b] Infant deaths per 1,000 births per year
[c] based on 1985–1986 life tables
[d] Average lifetime number of births per woman under current age-specific fertility rates

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Source: Helig, Büttner, and Lutz, 1990, pp. 6-7.

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they have participated in, indeed have been among the leaders in, a demographic evolution which characterizes western advanced industrial societies.[18] Both Germanies had their post World War II baby boom (1961-1967) followed by a baby bust. Much of the rest is familiar (concentrating for the moment on the West, which developed the policies and programs here in focus).

After the baby boom, men and women began to marry at later ages, to have children later after marriage and to have fewer children. There was a 40 percent fertility decline between 1967 and 1974; both Germanies were part of a European trend, but they were among the "leaders". When in 1985 Germany's total fertility rate had fallen to 1.3 it was the lowest such rate in peacetime, ever, and was discussed everywhere. Germany had a decreasing population (as did Denmark) and there was speculation as to the consequences. East and West Germany converged at 1.5 in the late 1980s as the eastern pro-natalist incentives which had created a surge from 1974 ran their course and the West showed an "echo effect" as the larger cohort of baby boomers had children. By now most of Europe is below the 2.1 replacement rate. Sweden is among the high fertility countries, in perhaps another calendar effect, and the European states with lowest fertility are Italy and Spain (matched by the areas of Germany once part of the East).

The birth slowdown and increased life expectancy since World War II have also led to a major population aging (with related pressures on pension and medical care budgets). About 15 percent of the population was over age 65 in 1990 but - because of the low birth rates - the dependent part of the population has remained at about 30 percent - not much of a change for the post-War period. Smaller nuclear families live apart from elderly parents (but early retirement prevails and grandparents are still important in the child care picture). Germany has less single parenthood than the Nordic countries, France, or Great Britain, but its rates are historically high - a generalization which also holds with regard to cohabitation and out of wedlock births. However female labor force participation continues to increase (see below), and a "permanently single" lifestyle alternative, as well as cohabitation, and single parenthood (if statistically exceeded elsewhere) have had a dramatic impact, given the historical strength of the traditional German family. These trends as well as high divorce rates (more divorces than marriages in both West and East Germany in the 1970s and 1980s) and low fertility rates constitute the arena in which family policy has been developing. Ninety percent of births are within marriage but "one-half of the children already born will experience the divorce or separation of their parents."[19]

Recent birth cohorts in West Germany have totaled 640,752 in 1987 and 677,259 in 1988. We do not yet have precise data for East Germany. As noted in the course of program visits in what was East Germany, there were extraordinary declines in birth rates in recent years (a fertility drop of 65 percent between 1989 and 1993), reflecting the trauma and uncertainties of the transition.

2. Mothers At Work

The tradition of the at-home mother is strong in Germany - that is, the West Germany in which the policies and programs here in review were evolved. As indicated in the several tables in our appendix, Germany has been in the Austria, France, Netherlands tier of female labor force participation (50-60%), below Canada, Switzerland, U.S. and U.K., all of whom were exceeded by the Nordic countries. East Germany, on the other hand, was with the Nordic group. Of the six countries reported in the table, Germany had the lowest participation rate for mothers of children under 3 and for single mothers with children under 3 (except for U.K.) (See Appendix Table A-9). Single mothers with children worked less than the married. Many of the mothers in the labor force are part-time workers, some because they must take what work is available and others because they cannot manage child-care and household otherwise. Germany is matched only by Austria in the OECD in the proportion that women constitute of part-time workers. However, Germany is below the OECD average in the proportion of its work force that is part-time. Nonetheless, these data also reflect a constant growth in female labor force participation in Germany over two decades in the 20-55 age groups. The proportion who leave work after marriage or the birth of a child has been decreasing - but many still do - and the proportion who return to the labor market after leave has been going up (about half or 60 percent of those on Erziehungsurlaub after it ends). (See Table FRG-6).

Table FRG-6

Table 3.2
Female Labor Force Participation by Family Status and Presence and Age of Children, 1987 (Women Ages 15–65)

	Number 000s	Total	Not in Labor Force	In Labor Force			
				All	Full Time	P-T 21-39 hrs.	P-T up to 20 hrs.
All Women with Children			(%)	(%)	(%)	(%)	(%)
under Age 15	5,571	100%	58.3	41.7	15.9	11.4	14.5
under Age 6	2,746	100%	64.4	35.6	14.3	8.9	12.4
under Age 3	1,590	100%	67.6	32.4	—	—	—
Married with Children							
under Age 15	4,944	100%	59.9	40.1	14.6	10.7	14.8
under Age 6	2,481	100%	65.4	34.6	13.4	8.5	12.7
under Age 3	—	—	—	—	—	—	—
Single, with Children							
under Age 15	628	100%	45.0	55.0	25.8	17.0	12.1
under Age 6	265	100%	55.0	45.0	21.9	12.8	10.2
under Age 3	13	100%	61.8	38.2	—	—	—
Married, but separated with Children							
under Age 16	104	100%	57.9	42.1	—	—	—
under Age 6	50	100%	—	—	—	—	—
under Age 3	23	100%	—	—	—	—	—
Widows, with Children							
under Age 16	69	100%	45.5	54.5	—	—	—
under Age 6	13	100%	52.2	47.8	—	—	—
under Age 3	—	100%	58.8	41.2	—	—	—
Unmarried, with Children							
under Age 16	174	100%	39.2	60.2	—	—	—
under Age 6	123	100%	54.5	45.5	—	—	—
under Age 3	80	100%	62.0	38.0	—	—	—
Cohabiting, with Children							
under Age 16	280	100%	—	—	—	—	—
under Age 6	79	100%	—	—	—	—	—
under Age 3	29	100%	—	—	—	—	—
All Women	21,628	100%	51.2	48.8	27.2	—	—
All Men	29,292	100%	43.5	56.5	76.9	—	—

Source: "Population and Labor Force Participation." Specialist series 1, vol. 3 *Haushalte und Familien* (Households and Family) (1987), p. 170 (Stuttgart: Federal Statistics Office, 1989); author's calculations.

Note: Empty cells indicate unavailable data.

Source: Kamerman and Kahn, eds., Child Care, Parental Leave and the Under 3s, p. 55.

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3. The Political Environment

In an analysis prepared just before the reunification, Schiersmann summed up as follows: "The question of child care benefits and leave is not a central theme in political discussion, particularly because most of the existing measures are supported by a broad spectrum of political parties, with differences of opinion confined to details."[20] The Christian Democrats (CDU) party was working on extending the child care leave and grants (as did occur) and the Free Democrats (FDP), also in the governing coalition, joined on this but protected employers against heavier burdens. The Social Democrats (SPD) supported extension, wanted to do better for single mothers and to protect those in the work force, compared to those who were not. The Greens urged going somewhat further in a pattern that increased options. As much may be said with regard to the other elements in the package, with CDU protecting tax concessions and SPD - especially when governing - building the child allowance system. A similarly strong consensus has recently evolved at the national level about the importance of Kindergarten provision for 3-5s, with the debate about all-day or not varied by the importance of female labor developments in different areas. Only after the reunification, however, did the Krippen issue reach the national level, and that when the SPD asked in the Bundestag what the situation was in the five new states, which would have difficulty sustaining Krippen coverage, and the government (after financing a six-month transition) offered its picture of some likely decrease but a modest one.

These German family policies and supports for the under-3s have developed in the context of a fair amount of consensus about welfare state matters in recent decades. The SPD focuses more on working mothers, the CDU and the DFP on traditional families, but neither ignores the concerns motivating the other - and, in any case, on family policy matters there is systematic reporting (a family report, a child report, a social report), a report from experts on child development (Scientific Advisory Board) and a consensus about general direction.

The CDU, leader in the governing coalition, is the conservative party, oriented to the market, but since Konrad Adenauer, that has been defined as a "social" market, a market adapted to social concerns and values, with government providing a secure social safety net and a rich array of universal benefits.

The Jens Albers definition is helpful:

> ... the term 'social market economy' is frequently used in place of 'welfare state'. In this sense the role of the state is to supplement the market as the best mechanism for the allocation of productive resources by social benefits, compensating for market failures in the distribution of incomes. The intervention, however, should be limited and not interfere too much with the incentive structure of the free market economy. This limited definition of state activity originated in the political philosophy of neo-liberalism and the social ethics of Catholicism, but should also be understood as a reaction to the bureaucratic state control experienced in the Nazi period and the presence of Communist collectivism in East Germany."[21]

By 1959, the alternative political force in Germany, the Social Democratic Party (SPD), had deserted orthodox socialism and endorsed the social market as well. Thus the switch from CDU dominated government (1949-69) to SPD leadership (1969-82) had remarkable social policy continuity - which has continued with the new CDU coalition in the 1980s and 1990s.

Turning to the somewhat different conceptual framework of Esping-Andersen (1990), Germany is located in the conservative/corporatist group of welfare states of central Europe, as contrasted with the liberal (in the traditional sense, Anglo-American states) and the largely Nordic social democratic regimes - the main variations in welfare capitalism. The corporatist states sacrifice some of free-market orthodoxy and efficiency, taking it for granted that social rights will be granted and that they are to be associated with (are thus protective of) class and status differentials. The state replaces the market as the provider of welfare but redistribution is quite limited. Because guilds, associations and churches are important participants in the bargaining and compromise that creates and sustains corporatism, church influence and strong support for traditional families tend to characterize corporate polities, which are common in Europe. Subsidiarity, in the form of priority for family over societal solutions, and the priority assigned to the voluntary sector and state governments (Laender) as opposed to central (Bund) government, are important manifestations. Class conflict is moderated in favor of a bargaining and consensus politics of "social partners" involving business, labor, and government.

Despite its theological origins, the subsidiarity principle has been substantially secularized in Germany and is a major component of public policy. It has two aspects:

- "Official" care is secondary, since the individual is expected, first, to use his/her own powers or resources or those of others with responsibility towards him/her.
- Priority and support are to be given to voluntary bodies that wish and are able to collaborate in performing functions provided for under social legislation. This does not decrease "overall responsibility" of official bodies.

This means that public bodies do not create establishments or implement programs if sustainable voluntary sector arrangements exist or can be created.

Under the much-cited "Karlsruhe judgment" of the Federal Constitutional Court all of this is explained as a division of labor (not theology), stressing individuation and solidarity and particularly as protecting the rights of a citizen to choose a suitable and personalized form of assistance, and the rights of voluntary groups to assist and to operate "in accordance with their own conception of themselves." None of this is intended to depreciate official bodies or to remove their final authority and overall responsibility.[22]

We already have seen the ways in which preference for traditional families affects German social policy. We have noted and shall discuss below the major roles of national associations of voluntary organizations and their local counterparts in the delivery of child care and personal social services. Also, consistent with the general philosophy, we found in our study of income transfers in eight countries that Germany (while consistently behind Sweden and France) was relatively high in generosity rankings for cash benefits provided the types of families that are the targets of family policy and progressive social policy (single mothers, large families, one earner families, families with unemployed members, the family with a mother home on maternity leave).[23] However, as is the case everywhere in welfare capitalist societies, high earners, small families, singles do better than those dependent on transfers; and work incentives are preserved. A subsequent study showed that Germany is not one of the more supportive countries among western industrial societies with regard to single mothers and their children.[24] Despite some recent easings, social assistance is not readily accessible to them because of their own parents' responsibility, it is urgent to work to manage adequately, and all-day child care or after-school care for the school-aged are not readily accessible.

Thus, we see here a family policy indirectly oriented towards the very young because it is oriented towards the traditional family, generous in U.S. terms but fully protective of work, the market, responsibility, and traditional institutions. Many of the programs on which we have focused are products of a decade which began with economic stress but recovered - and in which Germany has sustained one of the two or three leading economies in the industrialized west and before reunification, experienced modest population decline.

Comparative poverty data compiled by Smeeding and his colleagues, employing the Luxembourg Income Study (LIS) data set, show Germany with the lowest child poverty rates for eight countries early in the seventies and (with only five countries thus far analyzed) the second lowest, after Sweden, in the mid-to-late 1980s. Only the rate for one-parent families is out of line with other German families late in second period although for this subgroup, too, Germany's poverty rate is low in international comparisons. (See Appendix Table A-12).

ON THE GROUND

1. Introduction

We have not here included observation reports of child health programs or of family support services in Germany. As already noted, the child health services for most children are delivered by family-chosen physicians paid under the health insurance system. In most German states and large cities the public health offices have a relatively limited role related to the poor on the margins of society, foreigners, etc. Some home health visiting exists, but it is not characteristic. Given our objectives, we have not focused here. Similarly, since Germany is not concentrated on new family support initiatives, there are no visits to report.

Our "On the Ground" section for Germany focuses on child care: we offer excerpts from our observations in Wiesbaden/

Frankfurt in the West, Schwerin in the East, and both East and West Berlin. This study's main focus is on the under-3s. It will be recalled that while a high proportion of German 3-5s are in Kindergarten, the programs are mostly part-day and do not meet the "care" needs of families with two working parents or of one-parent families in which that parent holds an out-of-the home job. Efforts are being made to extend the hours of some Kindergartens and there has been progress.

For Wiesbaden/Frankfurt, where we describe Krippen for the under-3s. The reports indicate the beginnings of a development, with limited coverage and, thus, an inability to be neighborhood-based. We note the prevalence of a stigma-burden, given official attitudes. On the other hand, Schwerin in the East, where large-scale under-3 coverage was long taken for granted, is now uncertain of its future. That uncertainty generates some issues. The ground to be covered is underscored by the inclusion of the dramatic Kreuzberg facility, an exemplar in the Italy - Denmark - France league.

By way of background for Wiesbaden/Frankfurt, we note that in Hesse (Table FRG-1) which leads west German states in Krippen coverage (Berlin and Hamburg apart) the officials in the state's Jugendamt headquarters (with budgeting, funding, technical assistance and contracting functions), dealing with child care, child welfare and youth welfare services, see themselves as carrying developmental - socialization, preventive, direct service and treatment responsibilities. However, the delivery per se is through the private sector or local level municipal government. Under Germany's subsidiarity principle six national, voluntary peak associations and their local counterparts are the vehicles for much of the local child care and personal social service programs. The local Sozialamt (social welfare office), with a counterpart on the state level, administers social assistance and related general social services.

2. Child Care

The State of Hesse

The following visit reports make a more specific visualization of German child care possible. We shall concentrate initially on the state of Hesse and the capital city of Wiesbaden, a service center, and Frankfort, the large financial and service center. Then, we shall turn to Berlin and to Schwerin, in the old East Germany.

We make no claims as to Hesse's representativeness. It is an advanced industrial area, includes Frankfurt, as well as Wiesbaden and several heavily industrialized districts. Its under-3 coverage rate (1.5 percent, see Table G.1) was exceeded in the West in 1986 only by the two city-states, Hamburg and Berlin. It is here employed to illustrate programs, not to evaluate them. The programs visited were said not to be atypical.

Discussing child care, the Hesse Jugendamt leadership notes recent shifts in attitudes. As recently as six or seven years ago they were closing Kindergartens and discouraging their use, since the consensus seemed to be that work by the mother and Kindergarten attendance for the child was not a good idea.

However, there was a spurt of consumer demand four years ago.* Now there seems to be agreement that the "educational task of the Kindergarten cannot be filled in any other way. It is normative to attend Kindergarten at ages 3-5 whether or not one's mother works.[25] A child who is not included is separated from friends.

Hesse has been putting aside DM 150 million ($90 million) each year for important projects. The Kindergarten portion jumped from DM 80 million to DM 100 million ($60 million) in response to strong parental pressure and the widespread discussion of the now enacted law saying that states should ensure Kindergarten for all 3-5s. Now 90 percent of the 3-5s in Hesse attend. Also in the context of a changing view of women and work, the pressure has mounted to change more of the programs to an all-day status but here progress is slow because of the costs of the added staff required. There has been some improvement in opening hours - and the state is using its new funds to support program conversion to the longer "4-2 model" (8 a.m. - Noon, then 2 p.m. - 4 p.m.) or all-day hours.

This change process has not yet impacted infant/toddler care. The Krippen, which are all-day, but for the 0-3s are seen as meeting "special needs", so that available spaces are largely for children of single mothers, immigrants/ foreigners, children with handicaps or problems. There is ideological as well as practical resistance to expansion. The entire state had only

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* Other German observers note that the entry of mothers into the labor force has a longer history and must have been reflected in consumer demand.

2240 "places" in 119 centers in 1990, covering about 8 percent of the children of single parents and 2-3 percent of all the 0-3s. The family day care facilities, all informal and some grey market, added several additional percentage points of coverage.

Hesse, like all Laender, sets its own norms for child care, but Frankfort data, as compared with national information for the mid-1980s, shows it to be quite in line. The municipal Kindergartens, one-third of the total, limit groups to 15/20 children (average 16) and the staffing average is 1.55 professional staff per group. The municipal budgets show a 1:6 adult/child ratio in the municipal Krippen and 1:5 in the subsidized non-public facilities. However the actual enrollment ratio in municipal institutions was 1:4.4 in 1991 and the actual attendance ratio was 1:3.25. Participation of "foreign" children (many born in Germany) in Kindergarten and Horte (Krippe not included) involved 41 percent of all spaces in 1990; children with foreign backgrounds accounted for 35 percent of the population at the time.

There is acceptance of the idea that child care programs should take account of children's home cultures, and many are guest-workers and immigrant children; but it has proven difficult to recruit child care workers from Moslem groups. There is hesitancy among Turks, especially, to send girls to child care (and elementary school) so their Kindergarten participation rate is closer to 50 percent. Some changes are being noted in the "next" generation.

We visited a municipal facility (November, 1991) on a street called Hellkundweg in Wiesbaden. This center is open from 7:00 a.m. to 5:30 p.m. each day. It has 48 places for children ages 1 to 3, and thus is a pure "Krippe". This center has 6 groups of 8 children each and each of the groups is an "integrated" group, in that children aged 1 and 2 are present. There is a staff: child ratio of approximately 1 to 3 or 1 to 4. There are two staff members for each group plus an apprentice.

The center is located in a very lovely wooded area, but it is not near where most of the children live. Indeed, we were told that most Krippen, since they are in short supply, are located from a centralized perspective in neighborhoods where space is available and is not too expensive and draw on a city-wide target population of eligible children rather than serve children from within the neighborhood.

The facility was built five years ago specifically for this purpose. There is a broad deck off the facility that is roofed and can be used for outside play when the weather is bad. Some of the equipment is built by parents.

It was explained that the minimum age was 1 because of the parenting leave that is available to German parents. (The leave had been increased to two years by the time of our visit.)

When we first arrived in mid-morning there were very few children in the facility because most of them were out walking and playing in the park area in which the center is located, despite the fact that it was a rather raw, cold and damp day. We were told it does not matter what the weather is, children are outside walking and playing for at least one half-hour each day regardless of the weather. If the weather is good they are out for a longer period of time.

We were told that the program reflects a diversified set of pedagogical theories and theories of child development. An explanatory brochure specifies and illustrates the influence on the program from the theoretical systems of "Montessori", "Waldorf", a much quoted "Professor Mahlke", "Hugo Kükelhaus", and the innovations in Reggio Emilia (Italy). This program also is sensitive to environmental issues, so no plastic is used in any of the equipment or facilities other than the children's LEGO blocks. Everything is "natural".

When we went into the first group there were five children and two adults. One child was drinking from a bottle, a second had a runny nose, a third had a glass of juice. The children were quite relaxed, they were removing outdoor gear without any kind of help, talking back and forth to one another and to the staff member present. The youngest child in this group was 18 months of age. In general there was an atmosphere of sociability, individualization, active participation and verbal exchange between staff and children, and children with one another. The staff members were relaxed and related comfortably to the children.

As indicated above, the facility is very attractive and was specifically built for this purpose. As a result each of these groups has its own room. The rooms are set up in such a way that as one comes in, on the left-hand side there is a small room for the coats and the children's personal things, and on the right is a bathroom in which the toilets and sinks are child-sized. Straight ahead is a large room that is divided into three areas, one of which has a sink and a place for water play as well as washing up after meals. Another area has a couple of tables and chairs and then there is a climbing area and a kind of "house" with an upstairs and a downstairs that the children can play at. The far wall is the wall of windows with sliding doors that lead out to the deck. A portable oven can be brought into each of the rooms when the children are participating in cooking or baking. Of course all of the furniture and facilities are child-sized.

Although the hours here are 7:00 a.m. to 5:30 p.m., we were told that most parents pick their children up at 5:00 p.m. Some of the parents work only part-time and some are students. It was explained at several points during the day that in West Germany the ideology and philosophy is to ensure children maximum time with their parents and limit the hours in care. This is in contrast to the East where the concept was that a long day in care was perfectly appropriate, and indeed the day should be extended long enough to make time for the parents to shop without having to pick up their children.

It was also noted that in the enterprise-sponsored child care or in hospitals, children will spend a longer day in care than in other Krippen.

There is a very extensive waiting list of more than 100 children and an emergency list (for protective service cases) of 20 children. For the last year the only children admitted were those of lone mothers, low income parents, or protective service cases. It is generally agreed that there is a substantial shortage of places in the Krippen.

Thirty percent of the children here come from a foreign background. However, it was pointed out that at this age the children are all readily integrated. In contrast by the time they are 5 or 6 there may be more conflict. In general the children of foreigners who come to the Krippen become integrated rapidly and learn German earlier. Indeed from the Director's perspective those children who go into Krippen in general are more independent, better socialized, and have achieved a separation from their mothers that makes it much easier for them to adapt to Kindergarten. The children who attend the Krippen have better social skills, and this is documented in research. There is some research, however, that suggests that their language abilities are worse, but this may relate to the fact that Krippen children come more often from problem families. However, where the foreign children are concerned, the Krippe is especially important. The children learn better German, they become integrated early on, and they seem to help in the adjustment of their parents as well.

In a second group there were three children playing completely on their own without any supervision. In another part of the room the youngest child was being held by a staff person in her arms while he rested.

There were seven children present in the third group. We note that here, as was true also in some of the other groups visited, in addition to the rooms described earlier each group has its own sleeping quarters and cribs and these are apart from the playing areas used during the day. There is a common kitchen in which the children's meals are prepared. All the meals are prepared on-site and all use fresh foods. In other words, in this facility there are neither delivered meals, nor meals prepared from a central kitchen, nor are there frozen meals to microwave. The preparation of meals on-site is not characteristic of all Krippen. Each day the menu for the meals is placed in the front hall so parents can be kept aware of what their children are eating and plan accordingly.

When we entered the room where Group 4 was present there were eight children at a table serving themselves their lunch. There were three staff members. The youngest child was 1 year and 3 months old and the oldest would be 3 in one month. There were candles lit on the table, a tablecloth, and it was a very festive arrangement.

We were told that there is a strong emphasis on a so-called "family environment". Thus staff are required to eat the same food at the same time as the children do. The ages of the children are mixed, and they try to have a gender mix as well. If the child stays at the Krippe for more than one year, he/she will be with the same group and the same caregiver. Each group is linked to another group in such a way that if a staff member is ill, the children are integrated into the other group with a staff member whom they already know well. Where siblings are concerned, as long as the mother continues to meet the priority criteria for eligibility, they will have priority for a place and will be put in the same group as their sibling unless there is some special reason for separation.

When children begin at the Krippe, normally in the fall of the year, they are phased in on a part-day basis for the first two weeks. The concept is that that should occur if possible while the mother is still on her parenting leave, and therefore does not have to miss workdays. Otherwise, she may use vacation days.

Although the staff follow a highly integrated approach with regard to the children, there is nonetheless a separate staff lounge where there are staff meetings periodically or where staff may meet with parents.

When the Director was asked about budget-specifics, she had some difficulty providing the details, in part because staff salaries are paid directly by the municipality and there is not a separate budget that the Director uses for the facility.

The costs are borne as follows: Parent fees meet about 10 percent of the costs and all parents pay the same fee. The basic fee here is DM 160 per month per child ($96) plus DM 45 per month per child ($27) for meals. There are voluntary Krippen in which the parents have to pay higher fees, perhaps DM 800 per month ($480). The concept is that in theory there is a three-way division in the financing of the Krippen: the municipality; the voluntary agency; and the parent's fees. However, most of the time the parent's share is significantly less than one-third of the cost.

Policies with regard to fees and so forth vary by the states in Germany.[26] In Hesse all parents who have children attending the same facility pay the same fee. In many other states this is not the case and the fees are income-related, even within the same facility. There is some interest in trying to change the policy in Hesse to an income-related fee schedule, but it is not clear whether that will be achieved. In any case those mothers who are receiving social assistance have their fees and half the meal costs covered by social assistance. In addition fees are reduced for second children and free for third children.

With regard to staff salaries, Krippen staff are paid less than Kindergarten teachers. In this area (Wiesbaden) salaries are viewed as being much too low and as a result they are having a crisis in staffing the Krippen. Salaries are set by the federal government, the trade unions and industry, and although they have just agreed to a raise there is still some question as to whether it will be adequate to make for a competitive position.

Current Krippen salaries are about DM 2,800 per month gross ($1,680) in contrast to DM 4,300 per month ($2,580) for primary school teachers and DM 4,600 per month ($2,760) for a beginning professional position in a national social agency. Nonetheless, there has been surprisingly little turnover among the staff, and staff apparently feel very positively about the facility.

Discussion with directors and staffs on several other visits in the course of the day shed further light on the Hesse child care picture. In one center we were told that they attempt to keep the foreign representation below 50 percent so as to protect children's opportunity to learn German. In this and other centers the "foreign" children were well integrated and not very visible although they constitute 25-50 percent of the children in all centers visited. Another director spoke of the difficulty - but importance - of staff from the children's cultural background. There were no Erzieher (child care workers) of foreign background at a second center but one of the kitchen assistants (there are two) was a Turkish woman wearing the appropriate headdress. She was peeling carrots and biting into one occasionally. Once a week the children have what are called "wish meals" based on "their" food. In general there is an attempt to build some Turkish food and other ethnic food into the menu.

While some are municipally run and others are operated by non-sectarian voluntary groups, most child care facilities in Wiesbaden are under either Catholic or Protestant auspices. The Jugendamt representative with whom we made visits noted, however, that she did not even think of the religious connection when she was arranging for a place nearby for her own 4 year old. The issue was the hours and the ease of access, and from her point of view as well, the program.

At one Kindergarten/Hort open from 7:00 a.m. to 5:30 p.m. we were told that so many children are now listed that there is a three year wait for the Kindergarten, which means in effect that if a child is not put on a list almost immediately after birth, the child will be too old to enter the facility. We met this situation again and again in Wiesbaden and of course it was even more dramatic for nurseries, e.g. Krippe. Despite pressure they refuse to list children before the mother has actually given birth. All of this waiting list pressure in all day programs co-exists with stigma against all-day (as contrasted with part-day) Kindergarten and the Krippen - seen as used where there are special "needs", e.g., not serving the traditional middle class family with an at-home mother. (This assessment, we assume, varies very much in different parts of the country.)

Several all day centers strive to be neighborhood based but the municipality stresses "special need" groups - and these fill all the spaces. Children come "from everywhere."
For children in the 0 to 3 age group, Frankfurt has only ten Kinderkrippe and they are run directly out of a department in the Jugendamt. There has been a needs survey (a count of working mothers and single mothers), but no decision has been made as to the level of coverage to be provided in response to the numbers. There are currently 15,060 children in the 0 to 3 cohort, and there is a coverage rate of 9.8 percent consisting of the following: 687 places in municipally run Kinderkrippen; 200 places in the Krabbelstuben (roughly corresponding to the British Play Schools, but heavily publicly funded even though a parent cooperative); 170 places in Krippe run by businesses, e.g., industry-based child care; 410 formal family day care places (this number does not include grey market family day care). They do not really try to provide space for 0 to 1s since about 5,000

children in the above group would be covered by parents home on Erziehungsurlaub.

Child Care: Berlin

Before unification, West Berlin had a special status in Germany. It had little industrial development, proportionately few manufacturing jobs. Federal government subsidies were generous for the obvious political reasons. To attract and hold young people, those living in West Berlin were exempt from the draft and Army service. Much of the available work was in the social services and the types of people attracted to Berlin brought creativity and innovation. The plans and budgets of the Senate (the government) were fully supportive. Since the rates for single parenthood and two-earner families were higher than in the remainder of Germany there was high demand for day care and opportunity for innovation.

By late 1992 there were in West Berlin 70,000 places (Krippen and Kindergarten) in publicly operated facilities and 25,000 in voluntary, non-profit programs (of course, as we have seen, heavily subsidized). Of the latter, 10,000 places were in church-run programs (80% Protestant and 20% Catholic), 1,200 in worker/ union sponsored programs and 800 in miscellaneous facilities. Another 13,000 places were offered in facilities sponsored by secular groups, including 6,000 in neighborhood parent cooperatives. The latter were part of a considerable "alternative" social services development in the relatively avant-guard Berlin.

Tagesmütter (family day care mothers) are largely for the 0 to 1 children, while another variation of family day care serves the 1 to 3 year olds. The Tagesmütter are specifically limited to serving a maximum of two children while the other type of family day care mother has slightly older children and a maximum of six.

Fees are income-related at the centers ranging from DM 70 to DM 340 with an average of DM 200 - 250 ($128 - 160). The fee for Tagesmütter is DM 675 per child per month ($432), thus far more expensive than the center programs in part because they are viewed as being limited to infant care only.

Center staffing patterns are as follows:

AGE	# OF CHILDREN	# OF STAFF
0 - 1	8	1 1/2
1 - 3	10	1 1/2
3 - 6	15	1 1/2
6 - 12	15	1

Public Krippen are open from 6 a.m. to 6 p.m.; the private programs tend to have shorter hours.

While limited in amount, West Berlin Krippen accounted for over one-third of all western Krippen space before unification. In East Berlin, the participation rates were as high as everywhere in the East, almost universal after the leave termination, when the child was 1. Now, in border areas, excess East Berlin space is beginning to be used by parents on the west side who were on waiting lists. As everywhere in the five former eastern states, child care workers in East Berlin face the challenge of release from rigid, centrally directed program guidance and of encouragement to a diversity of program initiatives and "demedicalization" of Krippen programs once conceived of as medical facilities under nurses - but in transition even before the reunification. But their major preoccupation is with the stability of their jobs and with employment conditions and rules as unemployment and declining birth cohorts cut the demand for Krippen space and local government worries about unneeded expenditures.

No exemplars here, as yet, but we sketch one East Berlin setting for its contrast with Hesse - then we turn to Schwerin, also in the East, and to a far more attractive setting in the bohemian Kreuzberg area of West Berlin where "foreign" children are well integrated into a responsive program.

Kita Holtzmarkt, Berlin (A Few Discontinuous Vignettes from Two Facilities)

This is a large facility in what was East Berlin. Its current capacity is 86 children in the Krippe and 114 in the Kindergarten. Its earlier capacity was 240. (Regulations now set 100 places as the maximum). Berlin, like the other eastern parts of Germany, had a decline of over fifty percent in the size of its birth cohort between 1989 and 1991. This large facility is now conceived of as having two parts and the physical set up allows it. They are identified as such and they are called Kiko 1 and Kiko 2, each with some Krippen and some Kindergarten spaces, each with approximately one hundred children.

Each of these is a full day facility, in contrast to the dominant half-day Kindergarten pattern in much of West Germany. This is characteristic of the Berlin programs, both East Berlin and West Berlin.

Previously one of the facilities was a Krippe for children 0 to 3 and the other was a Kindergarten. As part of the transition, there is a shift to the philosophy of an age-integrated facility and each therefore now serves all children under age 6. The specific groups however are not age integrated. They do however overlap a two year age range but not more than that. In each facility the teacher (they use the term Erzieher for the person trained as an early childhood educator) stays with the group from entry to age 6 when the children then move on to primary school.

There are many long-term employees here, in fact some have been here since the building opened in 1970. In the East they are working forty hours, in the West thirty-eight and one half. There is some dispute about it because it effects the ratios and the compliance with the ratios which are as follows: Kindergarten 1 - 15; infants ages 0 - 1, a ratio of 1.46 to 8; small children ages 1 - 3, a ratio of 1 to 10.

East staff members are all trained as Erzieher. In the past, they did have some nurse-trained people and general assistants but they are no longer in this facility. There are still some such staff in some other facilities in what is left of East Berlin.[27]

Both Directors were trained as early childhood educators but one was trained in infant and toddler education while the other was trained as a Kindergarten teacher. They pointed out that today in Berlin the training of staff is the same for those in Krippen and in Kindergarten but in some other jurisdictions, there is a requirement for supplementary training for Krippen staff.

Children may come to the Krippe from the age of 6 months on (after maternity leave) but in Kiko 1 they have ten children between the ages of 6 months and 1 year, while in Kiko 2 there are no children under age 1. Before 1990 and reunification, they had significantly more very young children but as a result of the lower birth rate, there is no demand for more places for the very young.

In 1993 fees will be raised once again and they think this may become more of a barrier to parents placing their very young children in care rather than either making alternative arrangements or taking advantage of the childrearing leave. Fees now cover 8 percent of costs but in 1993 will be raised to 15 percent. In addition, non-profit organizations contribute about 10 percent of the cost by government regulation. Government pays the rest. There was some discussion about the implication of the basis on which fees are assessed because there is a distinction between operating costs and capital costs. However in the public facilities the government owns the facility and therefore there is no cost involved in the regular operations. In contrast, the private facility may be paying rent and therefore its basic operating costs are higher.

With regard to the number of places in each facility, although technically each one serves one hundred children, in reality Kiko 1 has 104 children and Kiko 2 - 114 on the rolls. Kiko 1 has forty-five children under age 3 and Kiko 2, twenty.

There was some discussion here as in the West Berlin facility as to whether in fact children under age 3 should be in care. In prior years there would have been no such discussion. Women were working and their young children needed to be in care. In some sense the more traditional West German ideology seems to be "infecting" the East Berlin debate. Some, also, did say however that since the cost of infant care is significantly higher than the cost of toddler care, this too influences the ability of a center to provide such places and perhaps generates support for the ideology, that the children are better off at home at that age. There was also discussion of the fact that part of the reduced demand has to do with the fact that employers don't like to hire women with very young children because they are likely to have higher absentee rates. This means that these woman are less likely to be employed, more likely to be at home, and once again therefore the demand for infant care in lower. If you add to this the availability of the child-rearing leave and a lower birth rate, the demand for places for the very young is clearly significantly lower than it was before.

The two centers are located in a housing development. There are several high-rise residential apartment house type buildings around a central grassed-in area in which these centers are located. The children who participate in the program, however, come not only from the immediate area, but from West Berlin as well. Indeed, about thirty children are from West Berlin, since this center is located relatively near where the Wall had been. There is no waiting list at present for the facility.

The facility itself should be thought of as having two separate buildings, each rectangularly shaped, one with two stories and the other with one story, attached near each end by two glassed-in passage ways. The passage ways have glass walls and ceiling, function something like greenhouses, and have extensive plants in each. There is a central enclosed area, therefore, between the passage ways and the two centers that can be used for playing and had tricycles and other kinds of equipment in addition to a surrounding yard area as well.

Describing Kiko 1: there is an entry hall, with a large room to the left lined-up with strollers left by the parents who had brought their children. One moves forward to a place where the clothing is removed and stored at the entry. Children come here with their parents from 7:00 to 7:30 AM. They are dropped off in the large room which is essentially a room with play space on the floor but there are eight cribs and playpens as well. And a small table for six. Next to this room, which is thus a combined sleeping and playing room, for infants, there is a large room with wash and toilet facilities. Indeed, it is as large as the room where the children spend the day, hardly the way one would design at this time. There is an extra room which is a shared activity room for several groups, since the "own rooms" are small. Here there are mattresses for jumping around, a slide, and a very attractive tunnel for the children to play. There are some rockers and horses.

This facility serves 45 children under age 3. One of the groups for the 0-1 year-olds is downstairs and the second one is upstairs. There are four groups for 1-2 year-olds, one downstairs and three upstairs, each serving ten children. Before 1990 these groups had sixteen children in the same space but that has been significantly reduced both because of the preference for smaller group size but also as part of the decline in demand.

The room for the toddlers, aged 1-2, upstairs, was designed for its 10 children and a little less than 1½ staff. We saw five children in the room, three at one table and two at the other eating lunch. In the changing room that was adjacent with the door open there was one child on the toilet, one being diapered by a staff member and a third wandering around. Before 1990 this room would have served sixteen children but now it was ten. In the adjacent room where the children would be resting there were sixteen cribs.[28] We were told that all of the cribs are going to be removed from this room and second group will be placed here but that the children will use mats rather than cribs for resting. Indeed the point was made that the children don't like the cribs, that the staff feel that the cribs are too confining and that they take too much space. In the future there will either be cots which can be stacked and put away in a closet or there will be mats which can be taken care of similarly; and

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these will simply be taken out when the children do their resting.

In this group the children did not seem to be particularly alive or responsive. They seemed very subdued and there didn't seem to be much interaction either between the staff and the children or among the children. It might have been because the children were finishing lunch and going to sleep, but nonetheless one did not have the sense of dynamism and vitality and outgoingness and excitedness that one found in some of the other programs.

On the other hand when we went downstairs to see another group of 0-1 year-olds there were four children (out of a maximum of eight) who were very alive and giggly and flirtatious with us and quite delightful and clearly very happy.

What one had a sense of here was that the focus was on providing good care for the very young children. They were clearly in a safe and secure environment, and there was interest in their development but it was not a developmentally-driven program in contrast to the good programs in Northern Italy and in Denmark.

Both observers noted that throughout this facility there was much less interaction between staff and children than one found elsewhere, e.g. much less stress on talking all the time. This means much less than seen in Berlin the previous day or that we would see Kreuzberg later in the day--or that we saw in most other countries.

We then visited the second building, Kiko 2. As one enters through the corridor one passes the shared kitchen which serves both buildings, staffed by one cook and two helpers. It had the usual kitchen equipment. This building houses eight groups. There is one group of 10 children aged 1-2, one group aged 2-3, two groups of 15 children each aged 3-4, two groups of 15 children each aged 4-5 and two groups of 15 children each aged 5-6 (the preschool groups).

There are enough places in this facility as well so that anyone who wants to can have a place. There is no waiting list. Before, the priority was for children of working mothers. That is no longer the case and there are children of women who are seeking or exploring work.

The first room we entered, which was a room for toddler-aged children aged 1-2, had four children present. Four of them were sick and two were on holiday. (Wednesday was a special religious holiday and a number of people in Germany take the rest of the week off or take long weekends). There was one staff member there talking to the one child who was still awake. The other children were sleeping on cots, snuggled down under quilts. The room was cool, the windows were open, there was plenty of fresh air. Next to this room was the standard toilet, sink and changing room. Throughout this facility these were spacious rooms with child-sized sinks and several changing tables. We noted that there was the same patterned hand towel for each child on the child's special hook in the changing room. All of the big laundry items such as sheets, towels and so forth are sent out to be laundered. Personal things are washed here in a washing machine/dryer setup. The parents provide diapers themselves.

From there we were brought into one very large room that's designed for physical activity for all of the groups within Kiko II. There is climbing equipment, space for running around and so forth. There are mats for jumping up and down, again a tunnel to play in. All of the rooms were airy and the windows were open in each room we entered. We were told that before 1990 and reunification the groups were larger both because of the government regulations which permitted larger groups and because there was more demand for places. At this point there is both a philosophical concept that quality is better when the groups are smaller but in addition they are sustaining higher staff/child ratios as much as possible because there is a conviction about sustaining trained and qualified staff now, despite a smaller demand, with the assumption that demand will rise within the next few years as female employment increases.

The administration changed in the middle of 1990 from the previous setup in which the Kindergartens were under the cultural ministry and the Krippen under the health ministry, to the present situation where they are combined under the Jugendamt. We asked what effect this had, expecting to hear something about the environment, the culture, the focus of curriculum and instead the response was about salaries of teachers. They originally lost 40 percent of their salaries and then some of it was recovered and now they are back to about 80 percent of where they were. These personnel were not focused at all on the substantive effect of the shift but on how it affected staff, and they talked in various ways about staff status, etc. It was a difficult time of transition, with many unknowns. Now whether working in Krippe or Kindergarten they are all Erzieher; the nurses are gone. There are some funny remnants of the old rules: if a Krippe teacher is working in a Kindergarten there is loss of pay; if a Krippe teacher is teaching in a Krippe it is the same pay as the Kindergartner. Eventually all this will be normalized.

Of the two directors in this Kiko one has been working here in this very building for twenty-two years and one for ten years. We asked about how the operations had changed over the past three years and they didn't talk much about program, either. Again, they talked about the fact that there was now more bureaucracy, more forms, more accounting, etc. They lost the finance specialist on the staff who used to do all of that. People are either not noticing or at least not facing the substantive involvements in the shift. Or, perhaps the answer is that they are not yet dealing with this change.

They previously had a separate director for "pedagogy" as well as the one mentioned above for financial matters. Now one individual is responsible both for pedagogy and for the budget and this is an important constraint. If there are too few children it may have impact on the curriculum but more important to them, they could lose their jobs.

Before, they had a specific curriculum plan that was imposed on them from the ministry. Now there is no such curriculum and it is completely dependent upon the directors. These directors who have been socialized into a very authoritarian pattern with little if any autonomy now find themselves expected to be creative and are confronted by parents who are very interested in what the experiences of their children are and whether or not they are being prepared for school and how they are being educated. Parents ask them and the staff: "What are you doing with our children?" "Why are you doing...and not...?" The staff are not yet fully prepared to answer.

A Center in Kreuzberg

This is a child care center, a Kita, for 50 children in the middle of Kreuzberg, the "ghetto area" which combines a large Turkish population with a certain number of people involved in the alternate cultures and politics of Berlin. There also is an increasing amount of gentrification as seen in the reconstruction in which this building takes part. Indeed one of the features of the building is the unusually attractive facility built into the reconstruction of an old building and allowing two floors and a basement area for the child care program.

The center serves 50 children, ages 1½-6, from the immediate neighborhood, on two floors on which two apartments have been renovated so that they are specifically designed for child care. There are two groups of 25 children each covering the full age range from 1½-6, with 25 on one floor and the other 25 on the floor above. There are three teachers (early childhood educators) per group. Two of the teachers are of German and one is of Turkish background. About half the children are of Turkish background and indeed keeping that population from going beyond the 50 percent mark is an important criterion in selecting children for each new group.[29] As part of the sensitivity to the multicultural backgrounds of the children there is a big map of Turkey that is kept on the wall near the entry and it is marked to locate where each child's family comes from in Turkey.

This reconstruction has won many architectural prizes; this is an extraordinary facility in contrast to the rather drab places we had just visited in East Berlin. Indeed it would be a prize-winning facility in any country. This old building has been renovated at great expense, the floor is clean and shellacked, everything done in light woods and featuring an S-shaped corridor that divides the space between the rooms and has glass walls, so that anybody walking along the corridor looks into either room and sees what is going on at any point in time. The rooms, in addition, have high windows on the outside walls overlooking an inner courtyard which makes for a good deal of light and brightness. The pattern and decor are exactly the same on both floors since each floor includes roughly the same group and age distribution having similar kinds of programs.

It is quite clear that the philosophy of the program as carried out by the director has been significantly influenced by Reggio Emilia (see Italy "Case"). As a result each group of 25 children is subdivided into three small groups of seven or eight children each, with one teacher. It is not that these are permanent subdivisions but these are subdivisions that are organized around particular activities which change from day to day. Indeed when the children meet in the morning and have breakfast the teachers then announce what the three activities are going to be for the group and which teacher will have responsibility for which group. Then the children themselves choose which activity they want to be part of (or which staff member they want to be related to) and this varies obviously from day to day. If too many children choose one particular activity they are encouraged to try something else but it also serves as notice that either a staff member or the activities need to be adjusted the following day.

At the end of each program year the older children are moved out and the space is used for children in the very youngest category. The center features a very well-organized and specific transition period for the children.[30]

It should be said, first, that a good number of children were already asleep and therefore we could observe the little ones on each floor in one of the rooms as we walked along the corridor. The small group of older children who were not sleeping were at the end of the corridor on each floor and in the room used for games and crafts. Thus the existence of one room for quiet play and sleeping and activity is very functional since the 25 children on each floor cover the range 1"-6 and there are inevitably some who are not sleeping. The ones who were awake were heavily involved in arts and crafts, various kinds of play, and in interaction with one or two adults on each floor. We were told that staff work very hard on the distribution of children in those groups to get a good mix between German and Turkish in order to enhance the speaking of German. In keeping with the facility and the attitudes of the director, there is an emphasis here on natural food and health food, there are no sugars used, no preservatives. The environment is modern and clean. This is the only place we saw on this trip in Germany where there are stalls surrounding the toilets. The feeling is that this is an area of privacy as children grow up, and why shouldn't it be an area of privacy for little children. In contrast, dramatic contrast, to the previous day in the "East", the equipment is modern, colorful and there is an emphasis on creative artwork. In the inside room there are shelves of supplies involving paper, paints, clay, etc., to which the children may help themselves as they want to work. In contrast to facilities in many places, whether Germany or elsewhere, there are not a lot of supplies strewn on the floor and blocking most of the playing spaces. Things are on shelves, but the children have easy access to supplies when they want them and need them. The Erzieher, on the other hand, also have a supply room and they can bring other things out and put them on the shelves to which the children have access.

At no point during the day, except during the sleeping hours, are the twenty-five children on either floor denied access to either of the two rooms. Whatever their age they may go from one to the other and they may play in the area that they choose. This, in short, is not a regimented place.

Each child has a storage container or compartment on a shelf of file boxes and proudly takes it down and shows his/her collection of paintings, constructions of various sorts, etc.

which have been saved. Indeed an expression of interest in one child's box inevitably yields a showing of a number of boxes. Each of the boxes has the child's name on the outside so the child can find his or her own box. When the box is full the child takes it home. When the box it is at the center the child brings his mother or father to look at it and to see the things he/she has done lately.

On a wall on each floor there is a photo essay showing the daily routine so the parents can see pictures of what the children are doing in the course of the day, explaining the program in a way that we did not see it explained the previous morning.

In one corner at the entrance to the second room there is an area for role play, a good collection of adult clothes and hats of various sorts, and good mirrors. Again, we had not seen this kind of area anywhere in East Germany and, on the other hand, it appeared here and on the first day in the old West Germany, this being something one would see in child care almost anywhere else in the world as essential to fantasy. Here, again in contrast to East Germany, children are not expected to nap if they are more than three years old. The others were playing and were active.

In the second room, where the slightly older children were, there were nine children and two staff members. Five boys were playing together in a corner on the floor constructing something with LEGOS. In another part of the room four girls were sitting around a low table painting and listening to a staff member read a story at the same time. It was quiet but it was alive, and there was enthusiasm and a lot of child-to-child interaction as well as child-staff interaction.

The facility was opened in March 1989. The director, a very attractive and articulate young woman with a lot of enthusiasm about children and many dramatic qualities, all in evidence as she talked to us, has been here since it began. She has worked for ten years in the field, largely with Turkish children and Turkish families. Before that she had been working in a public facility that was significantly larger and she was enthusiastic about the idea of moving to this smaller facility where she could express her own philosophical concept of a child care center. In the context of our recognizing the Reggio Emelia influence and her responding with enthusiasm, confirming the impact of this experience, she showed us a "scrapbook" that she had made based on the experience. She had many photographs of the child care centers there and of the "Diana" program in particular. She talked enthusiastically of Prof. Malaguzzi, of the staff there, of the enormous influence that this program has had on good programs in Germany.

Downstairs, in the "cellar" area, there is one very large room for more "physical" activities. This is a room that has very little in it at the present time but is designed for active physical play including running, jumping, and climbing. She commented that the inner courtyard area of the building where the facility is located is not conducive to much outside play. When the weather is good the children are taken to a nearby park but otherwise it is very important that the facility has room for physical play as well. Adjacent to this room is an "atelier"--a studio set-up for extensive painting, clay-work and so forth. There are sliding doors which can be opened so that the two larger rooms and the central entry area can in fact be made into one enormous room. This is used for special social events such as a supper at which the parents, staff and children attend or theatrical performances.

This facility has a waiting list of 100 children. The director indicated that in selecting children each year she can make her own choices. The priorities are single-parent families, children who have siblings already in the program, children in families in which both parents work, and then a mix of age, gender, and a 50/50 ratio of Turkish and German children. Other foreign children are included in the German group count rather than the Turkish group.

There are regular parent/staff meetings. There is one meeting every other month for each group, and these meetings alternate with another series of meetings every other month for the entire program. The director is autonomous with regard to curriculum development, planning and so forth but meets with the staff regularly to develop group plans. She as well as other staff members may take short, specialized training courses to enhance their qualifications. Once a week there is a staff meeting, following the same pattern as another center in West Berlin visited earlier in the day. Staff meet on Wednesdays 3:30-5:30 p.m. Parents are told they must have a shorter day for their children at that time and pick their children up at 3:00

p.m. Parents complain but nonetheless it is felt that this is important because it is awkward to superimpose a meeting time in the evening on staff but sometimes that is done. About three or four children for whom alternative arrangements are particularly difficult to make, among the older Kindergarten age children, do remain here during staff meetings. The staff keep a general eye on them.

In some sense the feeling that the place can be closed at 3:30 once a week so that teachers can meet reminds one of the general pattern of elementary education and child care in Germany where the days can be short so that the teachers can have viable lives themselves and manage their own responsibilities. In many other parts of the world one would not think of closing a child care facility at 3:30 p.m. on the assumption that all parents can somehow manage. (But French facilities are closed on Wednesday afternoon and open on Saturday for a half day.) Nonetheless it should be said that there was no doubt in the mind of the director that these parents did manage and she could refer to the fact of the very strong extended family links that provide support for these families in this area. She commented that Turkish families have large extended families and somehow can always fill-in.

The staff meetings tend to focus on what she referred to as traditional child development and programmatic issues. There are issues that are of importance to the staff and issues that the staff believes are of importance to parents. One teacher is a man and this was a much discussed issue at the staff meetings and at the parent/teacher meetings because this is contrary to the traditional Turkish culture. Other questions emerge: whether guns are acceptable toys (they are not within the program), how much freedom to give children, what to do about aggressiveness, appropriate male and female child behavior, language training, and so forth.

As indicated above each group is divided into three subgroups of seven or eight children with one teacher. In devising the various alternative activities for the groups each day one group tends to be oriented around physical activity, a second group around quiet play and perhaps readings, and a third group around more creative play.

According to the director there are five other facilities of this type within this general neighborhood. Some of them are on one floor and some on two floors, all in remodeled apartments and reconverted buildings. If they are on one floor they tend to serve somewhere between twenty and thirty-six children depending on the size of the space; if they are on two floors they serve fifty children. In addition there are some very small parent-initiated centers that are under the umbrella of a slightly larger organization. This is all separate from the public centers which tend to have about 150-170 children and were purpose-built. She stressed the fact that Kreuzberg is a very diversified community and that the diversification is one of ethnic background, race and class variations. There is increasing recognition of the value of group experience for children. In this context she pointed out that the children that we were seeing were third generation Turkish children who really were very acculturated and German. These were not new immigrants. Therefore there was not the inhibition that we had been told of elsewhere with regard to letting girls participate in such programs.

We were also told that at the present time the government regulation on center size is that no center can operate with more than 100 children. (The East Berlin center visited earlier had been subdivided into two facilities). This was a compromise between the conservatives who really would have preferred something like a family day care program or very small family-like groups and the Social Democrats who wanted larger and more diversified groups in which the group experience was the dominant one, not the family model. The initial proposal in fact was for centers with a maximum of 70 children, which is the pattern in much of West Germany.

Child Care in Schwerin, In One of the "New" States in the East[31]

Americans will find no exemplars in Schwerin. We offer sections from our reports of visits to three different child care centers to suggest, further, the transition problems. Whereas the facilities had both Kindergarten and Krippen sections, we emphasize the latter.

Schwerin is a city of about 140,000, of mixed small manufacturing and agriculture in the state of Mecklenburg-Vorpommern. It is surrounded by a large agricultural area. The current government is dominated by a coalition of the CDU and the FDP which won the election after the unification. There is very high unemployment. The city is drab, has a lake in the center, and in the past has had some pretense for recreation and vacation, but the only feature one can see is what was a castle several centuries ago, and the remaining buildings of what were stables and places where horses were exhibited. In fact, the social ministry inhabits one of those building now.

The First Center

The first facility visited, open from 6:30 a.m. to 5:00 p.m., has forty places for Krippen children and eighty-three for Kindergarten children. Because of our late arrival, all the children were napping. Of special interest here is that even the 5 to 6's nap. In fact, we were told that in many places children also have a nap in the first grade.

The staffing ratios here are one Erzieher for eighteen children in the 3 to 6 age group and one Erzieher for six children in the 0 to 3 group. These of course are very high ratios by U.S. and general western standards. The 3 to 6 year olds recall the French École Maternelle. (The helpers lower ratios, of course.)

In a side discussion as we walked around, asking why there were several children under age one present, we were told that the mothers here have not been taking up the child rearing leave. The DM 600 is "nothing". They need more money and therefore either have to have a job or unemployment insurance. There has not yet been an increase in the cash benefit, they believe, although it is being discussed.

We asked about pressure for places and we were told that there is none and that there is a decrease in enrollment. This decline is attributed to the decline in births since reunification.

As we walked from sleeping room to sleeping room, we found an adult in each room. Unlike what we have seem in some other countries, the adult was sitting at a desk and either reading formally or making notes, rather than sitting in a rocker covered by a blanket and joining the children in the relaxed nap.

For the under-3 group we found that seven of eleven infants were all- day participants. There are three half-day participants in the age group 1 1/2 to 2; the remainder attend all day.

The faculty had started out by converting a school into a Kindergarten. There was no Krippe nearby. Then parents had complained and created pressure, and that is what created the forty Krippen space in this building (there are eighty-three in the Kindergarten). Although we probed there was no theory, no ideology, no point of view as to why these two facilities should be together (unlike rationales elsewhere about age integration).

There has been no possibility of adapting the facility physically to the new realities. Thus for example, the space available for the Krippe children had a large toilet/wash room which had been set up for a Kindergarten group of eighteen, e.g. a long line of sinks and of toilets. That, of course, was not now needed for the small group of children.

The food arrives here frozen or cold and is only heated. There is no original cooking. There is in some other facilities, however.

The routine is for the parents to come in with the child and to leave almost immediately, except when a child is fearful or new in the group, in which case the grandparents would stay for a while. Although we looked and probed and asked many questions, there was no sign of parents being around, except when they would be picking up the children later in the day. The one exception seemed to be a grandfather who delivered and picked up a child and who was expected to stay around quite a while. The adult presence is thus relatively sparse compared to other places: there are four Kindergarten groups and one Erzieher in each, and there are two Krippen groups and one Erzieher in each, thus six professional staff, plus the director who rotates and roams. There is only one cook to heat the food and there is some cleaning personnel e.g. one helper.

We discussed the program concept with the director and the representative from the Jugendamt. Clearly there is no unifying concept. These facilities in the East are trying to find their way and the way in which they are doing it at the moment is to be open to many concepts and points of view. Indeed, they also see themselves in transition, because encouragement is being given to the six large national voluntary non-profit associations to take over some of these child care facilities and become sponsors. We asked why new sponsors were being sought, since there is full coverage and excess space. What would they substitute for? The fact is they will not substitute for anything, they will simply take over existing public facilities. What they have now in Schwerin is a public takeover of what were many factory-sponsored Kindergartens which in fact did not close. There had been fifteen factory-sponsored Kindergarten here in Schwerin and ten still exist, now as public facilities. The non-profit voluntary groups will now take some of them over. The philosophy then is about sponsorship, not about program concepts, which will develop later.

When we asked about the age integration question, we were told they have age integration within each e.g. the Kindergarten ages and the Krippen ages. However, this particular facility has age-segregated groups. Nonetheless if parents want the child to be with the sibling, that is arranged also. They can be flexible now. One thus found a large number of degrees of freedom in the programming, with the leadership given to the Erzieher.

The Erzieher here have Kindergarten training, having gone to the Fachschule (a vocational secondary school) for three years and passed a state licensing examination. The job is popular and the staff is stable. Before unification it was considered a good profession and the staff were looked up to even though it was not well paid. They are paid less than school teachers. We asked about pay in detail and they had to do a lot of consultation to answer. It is clear that there are month to month adaptations, projections about the future etc. and nobody has the full picture. The intent is to pay the same salaries in the East and West by 1996 or 1998 and the transitional steps are confusing.

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The approximate current salary is DM 1,600 a month, to be increased shortly to DM 2,000 ($1,280). The parents pay DM 2.5 for Krippe food ($1.60) and DM 2 for Kindergarten food ($1.281) each day. The fee paid is related to income and amounts to about 1/3 of the cost. The estimate of the director (obviously not considering capital costs) is that it costs about DM 700 a month ($448) for a child in the Krippe and DM 500 ($320) in the Kindergarten. The family pays nothing at all if their income is under DM 1,100 net per month ($704).

The Jugendamt person was able to give us some numbers. In 1988 there were 10,000 children in Kindergarten in Schwerin. In 1992 they were down to 6,300. They attribute this to the birth rate decline. There are similar declines in Krippen registration, although she does not have the exact number. It is not that they attribute nothing to unemployment, but they think the birth rate decline is the main thing. They hear from colleagues all over the eastern states that this is happening generally. Parents are not keeping the children away from the facilities. If parents are employed the children certainly come here, but even if the parents are unemployed, parents must be ready to accept jobs and they need to have their children in care. And besides, the staff said, "children need to be with children in order to grow up." Even if both parents are home unemployed, it would be too stressful if the child were kept home as well.

Nonetheless some children are kept home because the parents cannot even manage the small fees for food or whatever else it is that they are charged. We heard here, also, the thing that we have been told from time to time, that there is no adequate play space at home and children need more space, and that is why they come to the facility. On the other hand, these interviewees rejected and laughed at the notion (repeated in Bonn) that East German mothers did not know how to take care of their children because of the long hours in the Krippe from age 1, and when the responsibility was thrust upon them as the result of unemployment and the cutting of child care, they were in a panic and that is why parent education had to be built up. They stressed, rather proudly that the children are quite mature, the mothers were competent, were managing work and family very well, that children were growing up well, whatever was being said in the West.

The facility works pretty independently; the person from the Jugendamt with us is the one person with administrative responsibility. They are now talking more and more about working with parents. They will develop more regular parent meetings, and the group leaders have begun to meet monthly. In short, one can hardly describe this as a model, since it is a program in transition. The only clear rule is the rule about staffing ratios: one to 18 in Kindergarten, one to 6 for the under 3's, and one to 22 for the Horte.

As to what occurred when the Krippe transferred from health authorities to the Jugendamt, they said that the health supervision is now gone (See Kamerman and Kahn, 1981). Parents are now expected to monitor things themselves and to get children to the doctor. Now a doctor comes only once a year to examine the children's health and a dentist comes once a year. Everything else is in the private system. As a result, there are more children coming without inoculations.

The facility has good outdoor space. There is a small outdoor area on one side but the back of the facility has a large open area sloping down to the City's lake. There is reasonably good equipment out-of-doors. None of this is luxurious equipment, nor are the supplies rich, or plentiful. Moreover, to describe the building one would say that it looked like a school house that had been converted to child care and the equipment was rather sparse. The rooms were high ceilinged and square, the window's curtained, the corners sharp, and the things to soften it quite limited. None of this is what one would design for little children.

Second Facility

This was one of the large facilities, quite characteristic of East Europe and East Germany. There were present on the roster 167 Kindergarten children ages 3 to 6, fifty-four Krippen children ages 0 to 3, and twenty in a Hort, to a total of 241 for the facility. Here the Kindergarten ratios were one to six, fifteen to eighteen children in a group. The under 3's were mostly 1's and 2's, since there were no 0 to 1's present.

This building had been built as a Kindergarten, but it might have just as well been a school. Again, high ceiling rooms, large windows, but none of the things that are built in facilities today. The equipment was adequate, not rich, the supplies available, but hardly colorful and attractive. Rooms were all off corridors.

Before the unification there were ninety children in the Krippen facility, not the fifty-four, and again most of the decline was attributed to the fall of birth rate, but some to the cost problem in relation to unemployment. As one entered, there was a changing room on the right and a place to hang all the children's clothing in cubbies. On the board was a message center for parents. Here each group has two rooms, a big room for action and play and a room for quiet activity and sleep, something we have seen in many places. The structure is such that there are two inner courtyards, and the inner courtyard has minor play space but there is a bigger area, quite adequate, outside.

One of the areas for the Krippe has a quite room which is mostly used for cribs, but also has some floor mattresses. The plan here, too, is to convert entirely to floor mattresses when they can manage them. One of these rooms had no toilets at all, since it was set up originally for new newborns, but there are no longer newborns here. The children, therefore, use potties.

In contrast with the first facility visited, where there was not much done about the identification of the children and their personal things, here we found what we have found generally in child care centers e.g. a child would have an animal symbol and there would be tiles with the animal symbols where the toothbrushes were kept, copies of the animal symbols where the clothing was hung, etc. In the midst of a visit to the Krippe, a

Kindergarten class arrived and sang for us three songs accompanied by guitar and two teachers. There was enthusiasm, the children knew the words, there was rhythm, and after each song the visitor was presented with a gift e.g. a painting made by three or four children, a little figurine, a paper puppet, a sailboat.

In one of the infant rooms one found one adult and ten children. Since this was higher than the official ratio, we asked about it and it was explained that the colleague had arrived early when the children did, therefore she had already gone home at 3 p.m., and now the other colleague was left with the children. This means that whatever the ratio is said to be, the coverage at a given moment can be much less.

The structure for the Krippe space in this facility is always an entry room with the clothes cubbies and bulletin boards, a toilet with all the proper facilities for changing and washing on the right, a large activity room forward and a small quite room and sleeping area to the right. The sleeping areas tend to have lined-up cribs, but there is a gradual conversion to floor mattresses.

Here they are open for the Krippe from 6 a.m. to 6 p.m. and most children stay eight or nine hours. They are all local children. The philosophy is to take them out of doors everyday if at all possible.

The comment above about the ratio of one to ten in one room should not be taken to mean that there is no individualization. Indeed, in another group, we found two adults with four children, one in the arms of one of the adults. This was a group from which most of the parents had taken holiday time off with the children and their siblings and there were a large number of absences.

There are plenty of spaces in Krippe here and all children who want space can get it. The Krippe leader spoke of her hopes for the children: independent children who would have good experience with other children and can share in groups. One did not know if she could translate this to what was going on, because clearly there is a great push as well for teacher autonomy and not much time, as yet, for the staff to develop a group philosophy and a way of implementing it.

Within each group there is age integration (0 - 3). The child will spend up to three years in a Krippe group and then three years in a Kindergarten. There will be continuity of the Erzieher in each. We visited the Kindergarten area in this same combined facility, not going to all the groups. Practically all these Kindergarten children had originally been in the Krippe on site. Most of them therefore had long relationship with at least one adult in the facility. They seemed competent, relaxed, and there was no frenetic quality at all. They were happy. On the other hand, unlike many places we have gone, there were very few things made by the children actually hanging, and few of the activities involved painting and construction. There was more playing with toys and playing with one another. Exceptions seemed to be the two big paintings made by small groups of children for the visitor, and from the way these were executed, one would say that these children are experienced in using the materials and working together.

There are working toward a general increased involvement of parents. The parents can say something to the leader when they arrive, but given these ratios the leaders will have very little time. They are planning to do parent evenings and if there is a special reason to do so, the leaders are expected to visit the home and talk to the parents after work.

All ten groups here have the same plan as described above, plus a room for wash and toilet facilities. Children come from all social groupings including some professionals, but there are no academics because this is a town without a university or higher education.

Over coffee after the visit to the second facility, it was possible to discuss the effects of the change somewhat more. The theme one got from the existing staff was that they had been proud of this place before unification and it was not a bad place. The main difference is that the Erzieher are now encouraged to express their individuality more and not told exactly what to do. There is stress on working things out in response to an interaction with the parents as well. As a result of all of this, they find the work "more fun" for the Erzieher than it use to be. Each group leader makes his or her own plans (really her) for the week. We were shown an attractive program booklet telling what they would be doing. Parents are being consulted more. When one probed all of this, it was not clear exactly how much was authentic and integrated and how much was really verbal, following the new leads from the Jugendamt. Their slogan is "Kindergarten is a help to parents."

On the question of attitudes to having young children in Krippen, they talked about their experience over the years, the fact that the children went on to the Kindergarten, and they certainly did not see children having bad effects because they were placed in Krippen when they were very young. In fact, to them, children develop better with the Krippen experience than if they stayed at home during the first few years. Their proof is to tell anecdotes from the development of their own children. They know that there is a different ideology about Krippen in the West but they reject it. They cannot cite research, however. On the issue of how to develop programs, they talked about finding children's interests and getting their cues from children (much as we have heard in Denmark) and they see no gender differences in the children's activity in groups or the experiences they provide the children.

Comments

The directors of the two facilities visited in Schwerin were alive and enthusiastic. This obviously makes a great deal of difference. The "tour" was too quick for one to assess the quality of staff. They did not seem to be talking as much as one expects of staff with the very young but they were also dealing with very large groups compared to what we have seen before. The children looked well and happy and one was impressed with the enthusiasm of the two groups that sang and gave us gifts. The children clearly enjoyed it. The second group had baked a "man" with a farina and sugar mix and decorated it beautifully and put a hook in the back so it could hang.

The physical facilities are nothing to boast about. An old school, an old Kindergarten building, and a converted residence. Nor is the equipment or the supply situation rich but this is as to be expected in the "poor" East. The factory facilities did not close down but were taken over by the public and now all are subject to the all out effort to turn as much over as possible to the private organizations.

The staffing ratios are low as compared to what we have seen elsewhere, but not compared to the École Maternale. There somehow seems to be somewhat less art work, clay work and expressive work then there is games and such. But this is not a fair generalization since the visit was a quick one. Nor did one see story-telling or dramatic work, but again it was too close to sleeping time in one place to expect everything to be going on. Children, as indicated, look all right, yet the ratio of children with eyeglasses and the numbers of relatively thin children seemed a bit high, comparatively.

There was no clear curriculum or program philosophy. They had been liberated from medicalization, and liberated from central curriculum, and now were being told to find their own way.

There is no pressure on space because of the declining birth rates and the unemployment, therefore there are no waiting lists. On the other hand, there is no hesitancy about infants in Krippen. They deny that parents can't take care of their children, but the parents see advantages in the children being in Krippe because the parents work and some of the teachers also talk about the advantage of the group experience.

All the facilities were having financial strains, all worried about losing children, and also the relationship of losing children to losing staff.

There were no exemplars here for the U.S. What was East Germany, which had rich Krippe and Kindergarten experience, is now needing to reinvent all that and is doing much of it under the guidance of the West - but in a period of economic stress and considerable uncertainty and insecurity.

CONCLUDING COMMENTS

Are German infant-toddler policies, or family policies, generally, explicit and coherent? One can find local experts with differing views. A top staff member in one national voluntary organization in the children's field, for example, says that policies are made separately because Kindergarten and Krippen are for children, whereas Erziehungsurlaub and Erziehungsgeld are for parents. In one of the three "social" ministries a responsible staff member is actively advancing the idea that decisions about Kindergarten should be made from a child development perspective and that an all-day program is not a good idea. In another of the ministries a staff member at an equivalent level of responsibility is seeking strategies to encourage employers or state governments to promote all-day child care programs so as to help meet the needs of working mothers.

We assume that any but a monolithic society would display tensions and contradictions in an important policy domain. Nonetheless, Germany clearly does have a family policy, some of it explicit, some implicit, some fully realized and some not, and all of it part of an ongoing system of societal change. The unification appears to have improved several benefits modestly and highlighted the Krippe issue briefly. A liberalized abortion law was soon declared unconstitutional, however, and a severe recession ended serious initiatives with regard to child care.

Overall, whether for the under-3s or the over 3s, the preferred family model of the long-governing coalition is the traditional family, one-wage earner, an at-home mother - until children have completed elementary school. Kindergarten and elementary grades are on a short day. Despite the dissatisfaction of working women, children are sent home for lunch, the alternative all-day programs are in very short supply as are the publicly supported after-school Horte. Child allowances and child-conditioned tax concessions are relatively generous (even though, as in many countries, they meet only a small portion of the costs of a child). The at-home mother is eligible for the Erziehungsgeld since "family work" is recognized for this purpose, a quite rare policy in international context. While women dominate part-time work, such work is not readily available and the child care supports are not adequate to make even that manageable for many mothers.

With regard to infants and toddlers the picture is very clear. The Erziehungsgeld and Erziehungsurlaub provisions, especially as recently enhanced, permit mothers in two-earner families - and occasionally fathers if the couple so chooses - to be at home for two years with a modest income supplement (increased to two years in January, 1993) and to have job protection for three years (increased since January, 1992). In some places the state may continue the income replacement for the third year as well. As pointed out, this policy, which began in 1986, is not good enough for the single mother whose family would have to live on the modest flat grant Erziehungsgeld, now DM 600 monthly. Her choices are continued work or social assistance.

But the governmental policy preference and support for at-home care of most infants and toddlers is undeniable. The failure to develop a significant supply of child care for them in what was West Germany makes this clear, as does the continued disapproval of the Krippen in public ideology. The limited Krippen supply is intended for "special needs", the unavoidable facilities for children with problems, children of single mothers who must work, "foreign" children. Of course the former East Germany had a large Krippen supply and over 80 percent of the children attended. There is little doubt that the Communist government employed these programs both to facilitate labor force participation by practically all mothers and to "socialize" children to their assigned roles.[32] This history does not help overcome hesitation in the West. What will occur in the East in the future will depend on state policies which, in turn, cannot but reflect the employment picture.

Also part of the policy is the recently enacted, and now enhanced, legislation which credits the mother towards social insurance entitlement, for the time, originally one year and now up to three years per child, spent at home in child rearing.

The official scientific advisory board proposes that three years of leave and three years of income replacement be guaranteed, and urges that men share the parenting leave on a more substantial basis, joining advocates in various proposals that would put a ceiling on the portion of the time that either parent could take. Behavioral science experts review world-wide research and advise that at-home rearing is better for infants and toddlers. On the other hand, there are important bodies of academic and political opinion who define the increase in female labor force participation as inevitable and desirable and they call for some modifications or enhancements. They, too, would back the three-year leave and grant, but only if parental sharing were assured. They sought to encourage and facilitate part-time work by the parent at home on Erziehungsurlaub, urging a dropping of the rule that one could work part-time only for one's employer, and if he wished it. A 1993 reform allowed part-time work for another employer if one's own employer agreed. (Others consider the further expansion of part-time opportunities for women as perpetuating the segregation of the labor market.)

Similarly, those who would place more emphasis on the development and protection of the female labor force role called for expansion of sickness insurance provisions allowing the worker time at home with an ill child, and they have recently been successful. On the larger issue of the redefinition of family roles of men and women - on which public policy may ultimately rest - an outside observer cannot predict whether long traditions will yield more than they have in the past.

Thus the policies are evolving in an arena in which traditional family values and the alleged advantages of infant and toddler rearing by an at-home mother are in tension with efforts to accommodate to the increasing participation of women, and especially the mothers of young children, in the labor market and the growing tendency to return to the labor market after childbirth - sooner or later. In Germany's case the direction thus far has also been affected by a latent pro-natalism, not stated as policy but certainly implicit. In its verbalized form, to return to the quotation from the Sozialbericht, it is put in these terms: "... to create conditions that will facilitate the decision to add a child to the family and that will ease some of the cost of rearing and nurture."[33]

For Americans, there is another essential observation. Whatever the resolution as between a long at-home leave for parents of infants and toddlers, or a larger commitment to other policies which facilitate simultaneous meshing of work and family life (particularly more part-time work and more infant/ toddler care), one cannot but notice the German government's commitment to the family. In comparative perspective, this is a conservative government with conservative economic policy yet it develops and expands children's allowances (and child-conditioned tax concessions), comes close to guaranteeing access to

Kindergarten to all 3-5s, has constitutional guarantees which permit the Federal Constitutional Court to mandate increases in child allowances or tax concessions so that no child will be without adequate income support (as defined by a social assistance program committed to providing a grant large enough for subsistence). And while it develops family education, family supports, and social service programs as needed (and here its arrangements will be familiar to Americans), none of this becomes a substitute for basic social policy.

Perhaps there is nothing in all this for Americans to copy - but surely there are things to discuss. The German experience helps to define issues and to clarify what may be involved in choices.

NOTES

1 Sozialbericht, 1990.

2 Wienaud, 1988, p. 8.

3 Since January 1, 1991, there has been a new, improved extra benefit for single parents of DM 600 per month ($384), subject to an earnings test following 6 months and eliminated at the DM 33,000 income level ($21,120).

4 An amended federal statute, dealing principally with abortion, passed in mid-1992, guarantees a child a kindergarten spot from age 3, effective January 1, 1996. This supersedes Laender laws. Implementation details are not yet spelled out and a delay to 1998 is under consideration because of economic constraints.

5 The January 1, 1996 guarantee could change this.

6 There were enough kindergarten places for 82 percent of the cohort in the West but some spaces were used by younger children and it was believed that 70 percent of the cohort were in active attendance. Some of the 5s were in the first grade, as well.

7 Bensel, 1991.

8 Bundesvereinigung Evangelischer Kindertagessatten ... 1989.

9 Tietze, Rossbach, and Ufermann, p. 65.

10 Ibid., p. 65.

11 Public health doctors complain that the private system is lax about regular check-ups, since there is a right to service, but no monitoring or outreach, and they claim that inoculations and immunizations cost far less in the public health office than in the private doctor's office. (Meireis, 1991).

12 One notes a degree of ambivalence about single mothers and their babies. There is considerable pressure for adoption, and social assistance is not encouraged. Under the law of parental responsibility, the young woman's parents may be required to support her (not her child) as an alternative to public assistance. On the other hand, there are resources to help if it will avoid abortion.

13 Kamerman and Kahn, 1991.

14 OECD in Figures, 1990, 1991.

15 Kamerman and Kahn, 1991.

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16 This was written before the changes in the summer of 1993.

17 Most of the numbers in this section are from Heilig, Büttner, and Lutz, 1990 and Familien Heute, 1990. Both of those sources document the generalizations in some detail. We also rely on our interviews and recent media coverage.

18 Familien Heute, 1990.

19 Heilig, Büttner, and Lutz, 1990, p. 23.

20 Schiersmann, 1991, p. 75.

21 Jens Albers, 1986, p. 4.

22 Federal Association of Voluntary Welfare Agencies, 1986, pp. 23-26; also Dirk Jarré, 1991.

23 Kahn and Kamerman, 1983.

24 Kamerman and Kahn, 1989.

25 We note on a national level, close to a doubling of Laender kindergarten expenditures between 1984 and 1990. (Sozialbericht, 1990, table p. 179).

26 An August, 1989 fee survey of West German states covering both Krippen and Kindergarten is available.

27 On earlier medicalization of East German Krippe see Kamerman and Kahn, 1981, p. 91, 152.

28 In the pre-reunification days infant facilities here as throughout East Europe were characterized by rows of cribs.

29 As is the practice in Germany, adults and children may be called "Turkish" even if born in Germany and second or third generation.

30 A detailed description of setting and program is available in a pamphlet (in German) prepared by the director Gabriele Pursian.

31 November, 1992.

32 Gormley, 1991.

33 Sozialbericht.

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SOCIAL POLICY AND THE UNDER-3S

ITALY - A CASE STUDY

Table of Contents

PAGE

INTRODUCTION....................................IT 3

FAMILY POLICIES IN ITALY........................IT 5

    Family Allowances...........................IT 6

    Child Care Services Including Preschool Programs....IT 9

POLICIES FOR THE UNDER 3s.......................IT 14

    1. Maternity and Parenting Benefits.........IT 14

    2. Child Care...............................IT 15

    3. Family Support Services..................IT 21

    4. Child and Family Health Care and Social Services....IT 26

CONTEXT...IT 30

    1. Demography...............................IT 30

    2. Expenditures.............................IT 33

    3. The Politics of Social and Family Policy.......IT 35

ON THE GROUND ....IT 39

CHILD CARE, FAMILY SUPPORT, AND HEALTH CARE.....IT 39

    1. Child Care...............................IT 39

FAMILY SUPPORT CENTERS (FAMILY CENTERS, CHILD AND FAMILY CENTERS, FAMILY TIME CENTERS)....IT 57

    1. Bologna - Maternal and Child Health Services...IT 63

CONCLUSION ....IT 67

NOTES ....IT 68

REFERENCES ....IT 69

INTRODUCTION

Italy has no explicit family policy, nor a social policy focus on the family as a unit. It has no coherent social policy toward family members, either. Instead, Italian social policy is directed toward certain categories of families and family members, in particular, children, pregnant women, poor families, families with a handicapped child. In many ways Italy's social policy is more child than family oriented. Yet, not surprisingly, it has no explicit or coherent policy focus on very young children (under age 3) either. It does, however, have some important policies and programs regarding parenting, child care, and health care and some rather inadequate policies regarding cash income transfers.

What national family policies do exist stress cash benefits for maternity, parenting, and child rearing, and they stress health and education services but not personal social services. Italy does not provide significant income transfers that substitute for earnings or supplement the wages of working parents. Some of the northern regions have particularly noteworthy child care programs.

Italy has no ministry for family affairs, nor is there any clear locus within government where responsibility for child and family related matters is placed. At the national level, the Ministry of Labor carries responsibility for family allowances and maternity and parenting policies; the Ministry of Health has responsibility for medical care, maternal and child health programs, personal social services, and infant and toddler care. The Ministry of Education is responsible for the preschool programs for 3 - 6 year olds as well as for primary, secondary, and higher education. The Ministry of Interior, which was once the only center of public social welfare in Italy, now carries responsibility for a variety of social services for youth. The recently established Ministry of Social Affairs has responsibility for family policy but has not yet acted on this. Its primary responsibility has to do with policies regarding drug abuse, the handicapped, children at risk, and child welfare services.

Further exacerbating the horizontal fragmentation of Italian social policy at the national level is the vertical fragmentation that results from Italy's four-tier government (national, regional, provincial, and commune or municipal). The national government is relatively weak and most of the responsibility for child and family policies is either regional or municipal. At the national level, cash benefits - family allowances and maternity and parenting benefits - are the most significant. Tax benefits (exemptions for spouse and dependent children) are quite modest and of marginal importance. Social assistance is modest, discretionary, and provided by local, not national government. Among the benefits in kind, education, including preschool or nursery education is most important and the responsibility of the national government. However, maternal and child health services and infant and toddler care, child welfare, related social services are largely the responsibility of regional and local governments.

In many ways, Italy is the epitome of categorical, decentralized, and targeted social policies. As a result, social policies are not coherent. They are disparate and inconsistent across the country and firm national data are often unavailable. Moreover, economic disparities between north and south further exacerbate the problem of standard of living inequities nationwide. Philosophically, the church/state tension continues to surface in various child and family policy debates. And, despite an explicit preference for a targeted policy strategy with a priority on the poor, Italian health and preschool education continues to stress the benefits of universalism (although current resource constraints may affect some universal services, especially health services).

FAMILY POLICIES IN ITALY

More specifically, Italy's family policies include the following:

- Family allowances
- *Maternity Benefits and Leaves
- *Parenting policies
- *Time off to care for an ill child
- Family law (especially divorce and abortion law and policy)
- Preschool Programs (*Scuola Materna*) for 3-6 year olds
- *Day Care Centers (*Asilo Nido*) for 0-3 year olds

- *Maternal and Child Health Services

In addition, Italy provides some modest income-tested housing benefits for families with children, a national health service, and a discretionary, locally provided social assistance benefit.

We discuss, first, the family allowances for children regardless of age and the preschool programs for 3 - 6 year olds. We then go into more detail regarding the benefits and services targeted on the under 3s and their families.

Family allowances are income-tested cash benefits provided to families with children, based on the presence, number and age of children. These benefits are not very generous, not indexed, but tax-free. Although benefit levels are adjusted periodically, they have not kept up with either wages or the cost of living. Eligibility is linked to employment status of the parents and limited to those families in which at least 70 percent of family income is derived from earnings (or receipt of unemployment benefits or pensions).

Family allowances were first established in Italy in 1933/34 during the Fascist period, revised modestly in the immediate post World War II years, and took their current form in legislation first enacted in 1955 and modified subsequently. Family allowances are paid as part of the head of the family's wage packet. They are explicitly designed to supplement wages of workers with family responsibilities by providing a cash benefit

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* Policies and programs targeted on the under 3s.

for each child in the family, beginning with the first. Benefit levels are the same for each child, and are provided until the child is 18 (or 21 if attending school or 26 if attending university) or without regard to age if the child is handicapped and cannot work. Family allowances are funded by a payroll tax paid by employers (at 6.2 percent of wages and salaries in 1991) and by a flat rate contribution from the national government.

Horizontal redistribution (from those with no children to those with children) was the initial purpose of the family allowance. In more recent years this goal has been partially superseded by concern with vertical redistribution (from those with more income to those with less).

Initially, family allowances were a relatively generous universal benefit but the benefit declined in real value dramatically, especially during the 1970s, as a result of inflation and the failure to index it. Since 1984 the benefit has been transformed into a selective or income-tested benefit targeted on low income families, and to a lesser extent, on mother-only families and families with a handicapped child (the income ceiling is 10 percent higher for lone parents and families with a handicapped child). Also since the 1984 legislation, supplementary family allowances are provided to those with the lowest incomes. Introducing income testing had the effect of reducing family allowance expenditures from 1984 to 1986 by about 46 percent; and it had the parallel effect of eliminating from among the beneficiaries about 30 percent of all working families with children and about 9 percent of families headed by pensioners. Families with incomes above 155 percent of average wage no longer qualify for a family allowance; and since a growing number of families have two wage earners, an increasingly large percentage of families with children no longer receive a family allowance.

In the late 1980s the minimum family allowance for one child was worth about 2 percent of average wage. With the low income supplement, the benefit was worth about 14 percent of average wage to poor families, and a maximum of about 25 percent of average wage to poor families with several children. Tax exemptions available to wage-earners with children were equal to about one quarter of the minimum family allowance.

Although single mothers constitute only a very small percentage of families with children in Italy and therefore a relatively small portion of poor families, the non-working single mother has no source of income other than social assistance. However, working single mothers are entitled to family allowance and special tax benefits and priority for child care. Divorcees who are awarded alimony are also entitled to survivor's benefits under social security.

Finally, of some interest, is new legislation at the regional level (in the Emilia Romagna region, for example) providing zero-interest loans for up to about $10,000 to middle class families in transitional situations. These loans may be made available to young couples setting up a new household, a woman following divorce, a widow, newly arrived immigrant families in need. Their major function is to protect families against experiencing a sudden drop in their standard of living, thus avoiding potentially traumatizing crises.

Child care services including preschool programs were initially seen as a social service for the poor and the vulnerable.[1] The 19th and early 20th centuries are usually characterized as years of no government interest in child care and preschool education, and encouragement of the church in carrying out its religious and philanthropic role. The origins of Italian child care programs date back to 1831 when the first child care program was established as a charitable shelter by the Catholic Church. Early preschool developments were under the aegis of the Ministry of Interior and linked to public assistance.

Acknowledgment of the educational and socialization aspects of child care programs only began to be discussed after World War II but national legislation assigning a specific governmental role in the establishment of public preschools was not enacted until 1968. Until then, the family was viewed as having the primary educational and socialization role for children under age 6, with the Church and other private charitable organizations as the only extra-familial institutions sharing that role. Legislation establishing compulsory education was enacted in 1860 but the limited interest in preschool is reflected in the coverage rates during these years:

- 1861 - 4.4%
- 1900 - 14.3 %
- 1920 - 25.0%

Contemporary preschool education in Italy dates from 1968 when national legislation (Law 444) formally assigned to the national government and the Ministry of Education the major role in the establishment of preschools for children aged 3 to 6. The initial focus was on expanding the supply of programs, giving priority to economically depressed areas and rapidly growing urban areas. Funding was provided by the central government to establish and operate preschools. Regions were to pay only for meals and transportation; and municipalities were to have responsibility for the actual physical facilities.

The family was still defined as having the primary role in child care, and staffing was initially limited to women only; but an education focus replaced the earlier custodial orientation and link with social assistance. The author of a report on child care in Italy, prepared for the EC, writes: "education, training and care of children [is] a social responsibility, involving the whole of society and not only the parents, with the direct participation of the state and the community."[2]

The 1970s saw a dramatic increase in the numbers of preschools and by the early 1980s coverage rates nationally were 85 percent reaching 89 percent by the close of the decade. Adjusting for regional differences, coverage is more than 90 percent in north and central Italy and about 80-85 percent in the south.

The national preschool delivery system today is a tripartite system made up of nationally funded and operated "state preschools" (48 percent), other public preschools that are either municipality funded and operated with a state subsidy (13 percent), operated by other public agencies (4 percent) and private preschools including religious schools (21 percent) and private lay operated schools (14 percent). All are under the aegis of the national Ministry of Education either directly (state schools) or indirectly.

In addition to the decision to invest public resources in public programs, among the factors leading to the growth in state preschools during the 1970s and early 1980s were:

- the growing view of preschool as a child's right and as an important universal experience for all children as more middle and upper class children were enrolled in addition to the poor;
- the recognition of the value of preschool for preparing children for primary school;
- the growth in female labor force participation and parents' need for extra-familial child care;
- the greater parental awareness of the value of group experiences for the social development of their children;
- the declining birth rate and consequent ease in serving a higher proportion of the cohort in the same number of facilities;
- the smaller size of families and their greater isolation, leaving children increasingly isolated at home and in their neighborhoods and parents seeking socialization experiences for their children;

- the decline in the availability of qualified staff in religious schools;
- the apparent preference of parents for the public preschools - as compared with private schools - because they are thought of as being of higher quality (safer, cleaner, better trained staff, more sensitive to children's needs).

The purpose of these preschools is "education, development of the child's personality, assistance and preparation for compulsory schools, ...supplementing the important role of the family...".[3] In addition to the mainstreaming of handicapped children, another overarching objective is "to overcome any disadvantages arising from family and social background, so that children start compulsory schooling on equal terms".[4]

More than half of the 91 percent of 3-6 year olds attending preschool attend state schools (46 percent), 13 percent attend schools operated by municipalities, 3+ percent other public schools, 19 percent attend church sponsored schools and 10 percent private lay administered schools. Almost 70 percent of the children attending preschool do so for over seven hours per day. Those not enrolled are likely to be cared for at home, by grandmothers. Family day care is largely non-existent. Unfortunately, with primary school covering only four hours a day in much of Italy, especially in the south, and only 15 percent of children in full day primary school (8 hours a day) many children - and their parents - experience something of a dislocation when making the transition from a long preschool day to a short school day. However, a primary school reform that was recently approved is expected to lead to a longer school day throughout Italy.

Programs are open about 8-10 hours a day from about 8:00 am to 4:00-5:00-or 6:00 PM, ten months a year (from September to the end of June), and still longer days and years if they have adequate staff. Some municipalities organize special summer programs for the month of July. Classes typically have twenty-five children. These programs are free, universal, voluntary, and available to all children whose parents want them to participate regardless of mother's (or father's) employment status or family income. Parents are charged fees only for meals and transportation, and these are quite modest. Eligibility is limited to children from the age 3 to 6. Where there are shortages of places (largely in the south and the islands) priority is given to poor children, orphans, children in one-parent families, handicapped children, children of immigrant families, older children. Nonetheless, by now, supply is adequate in the north and central regions for all who apply. On the other hand, those who are not enrolled tend to be the most deprived including those in the south and the islands.

Although the most innovative programs have continued to emerge in the municipal preschools, especially in the north, the state schools have increased in numbers the most over the past decade as more localities experienced resource constraints and the central government continued to invest in preschools. The state preschools increased most in the south, by deliberate policy, because the region had the greatest shortage of places.

Among the issues now debated regarding preschools are:

- expanding coverage to the full cohort;
- integrating all public schools (national and municipal) into one system and holding private schools to the same standards.
- improving program quality through improved teaching training and credentialing;

POLICIES FOR THE UNDER 3s

The turning point for social policy and the under 3s was 1971. Here, Italy has some important national policies but the most innovative developments are regional (in particular in the north) with regard to child care and family support services.

1. Maternity and Parenting Benefits

National legislation (Law 1204) established a mandatory five month paid and job protected maternity leave for all wage earning mothers at the time of pregnancy and childbirth. (Subsequently, agricultural workers, domestic servants, and recently even professional women and the self employed have been covered by this policy, the latter by a benefit pegged to average wage.) The leave begins two months before expected childbirth and ends three months after. A cash benefit replacing 80 percent of wages is provided through the social security fund. Civil servants receive their full pay while on leave and many collective bargaining agreements require employers to top the social insurance benefit and pay an additional benefit covering the remaining 20 percent of wage.

The law provides as well for a six-month, optional, supplementary job-protected leave payable at 30 percent of wage (higher for civil servants and many unionized workers). Fathers are entitled to this benefit only in the case of the death or severe disability of the mother. All full-time working mothers are also entitled to two hours a day of rest time during the first year after birth (and one hour for those working less than six hours a day). Parents have the right to take unlimited unpaid job-protected sick leave to care for an ill child under age 3. (Civil servants receive fully paid leave for the first month, 20 percent for the second, and unpaid leave thereafter.) Adoptive and foster parents of children under age 6 have the same right to the three month leave following adoption and the optional six month leave after, for children under age 3. Other personal leaves are often available as well.

2. Child Care

The modern day care center (*Asilo Nido* or day nursery) serving children aged three months to three years dates from 1971, when national legislation (Law 1044) was enacted giving all mothers the right to use publicly funded nurseries for the under threes but giving working mothers priority for places. Services are available "by individual request" meaning in U.S. terms that they are "optional" services and charge user fees. The law decreed that the national government should play an active role in funding these facilities but that regional and local governments should have responsibility for their operation.

The origins of these programs, however, like the preschools described above, were the charitable shelters established in the early nineteenth century, and subsequent twentieth century developments that linked child care to the workplace. Only after 1971 did care of the under 3s begin to be viewed as a community responsibility and part of the community's social infrastructure. In effect, child care services first developed as a social service, second as a support service for working women and a labor market service. In the last two decades child care - even for the under 3s - has begun to be seen increasingly as an educational and socialization service for all children, in addition to providing care for children with working mothers, and an experience that will rectify family deficiencies and overcome social difficulties. It is still not viewed in the same way as the *Scuola Materna* which is now universally viewed as an essential socialization and educational experience for all children. But increasingly, this is the view held in those regions where the developments for the under threes are most advanced. Of some interest, a 1984 survey of parents found that child care for the under 3s is valued not only because it meets the needs of families with two working parents, but because of the "opportunity the child is offered to relate to other children of its same age".[5]

The Ministry of Health is the central government agency with responsibility for these programs but the national government has made no financial contribution to these services since 1978 and never played a significant role in their development.

In contrast to the preschool programs where the national government has primary responsibility for funding and operating programs, regional and local governments are the responsible agencies for funding and operating day care centers. They assign administrative responsibility within their respective governmental systems. Also, in contrast to the preschool programs, the health care component is still very visible in these programs.

Employers contribute 1 percent of payroll taxes (social security contributions) to the Ministry of Health which allocates these funds to the regions for planning and development of "infant education" services. The regions in turn allocate funds to the local authorities for capital expenses and some training costs. The municipalities fund the operating costs out of their own contributions and parent fees (income-related) which constitute between 5 and 36 percent of operating costs.

The *Asili Nidi* cover the full work day, and are often open 11 hours a day from 7:30 AM to 6:30 PM (but at least to 4:30 PM). The programs are designed to serve children aged 3 months (usually 9 months to 1 year) to 3 years with working mothers or single mothers. Centers range in size from twenty-five to sixty-five children under age 3, but the preferred size in between thirty and sixty children. Classes tend to be age related: 3-12 months; 12 - 24 months; 24 - 36 months. In Centers with sixty children, there are likely to be four groups, including one for children aged 12 to 18 months. Group size for the under 1s is limited to a maximum of 15 children while groups for the 1 - 2 year olds usually have 15 - 20 children. Quality standards are set by the regions. In the Emilia region staff:child ratios are one teacher to six or seven children aged 1 and 2, and higher ratios of adults for infants. In the Centers with sixty children including fifteen babies, there are eleven teachers, four auxiliary staff and two cooks. In a center with forty-two children and no infants (under 1), there are usually six teachers, two auxiliary staff, and one cook. But these standards vary across the country and some communities have lower - or higher - staffing standards.

In 1990, staff worked thirty hours a week, five days a week in direct work with children and another six hours a week in planning in-service training and supervision, parent meetings, etc. Staff are all public employees; salaries are pegged at the "mid-level" civil servant salary. Staff salaries constitute about 80-85 percent of program costs. Staff have secondary school degrees or university degrees although they may still not have specific training in early childhood education, and there is concern about this. Elected parents' representatives are actively involved in the management committee of the centers but not involved in hiring staff or the day-to-day operations.

It is generally agreed that there is a substantial shortage of day care places nationally with coverage only for 6+ percent of the cohort. Current estimates of "need" based on the rate of labor force participation of women with very young children is 20 - 30 percent. This is based on the assumption that some parents will prefer to use relative care and will have family members to provide this care; and some parents will use in-home care.

All day care centers for the under 3s are public and almost all are operated under municipal auspices. There are very few private centers (even nonprofit, and almost none for-profit) and those that do exist are not well regarded.) Eligibility for the available places is limited to children of working parents, single parents, the poor, and handicapped children. Yet despite this, most children who attend are from middle and upper class families. At the end of the 1980s, about 60-70 percent of the under 3s with working mothers were cared for by grandmothers and about 20 - 30 percent by domestic servants or other relatives. About 6 percent are in centers. There is no formal family day care in Italy and most believe there is little informal family day care as well. In contrast, as indicated above, many Italian working families make extensive use of domestic servants to provide in-home care.

There are large differences in the supply of centers between the north and south, in part a function of differences in female labor force participation and in attitudes toward women with young children working. The south is far more traditional in its attitude toward women and work, and out-of-home non-relative child care. Thus, coverage rates range from 20 percent in Emilia to 1 percent in Calabria and Sicily.

There are three models of day nurseries: custodial programs (which have largely disappeared in the north); those that stress a more formal, structured approach to providing care and education; and a child-centered model with a curriculum that is developmentally oriented. The last is the dominant model in the Emilia region, the region best known for innovation and quality in child care programs.

In the course of the 1970s and 1980s, the northern and central regions took advantage of the resources made available to develop an innovative system of infant and toddler care. In contrast, in the south, either because of lower demand (lower rates of female labor force participation), more traditional attitudes, ineptness or corruption, developments were far more limited.

The Emilia region has been in the forefront of these developments, establishing an internationally recognized, innovative system of infant and toddler care under the auspices of the public education system. This region has female labor force participation rates that are close to those in the U.S. and Canada (64 percent of women with children under 10, working largely full time). The region now has 340 day care centers with coverage for more than 20 percent of its under-3 cohort; and Bologna, its capital, has places for more than 30 percent. Given current patterns of need, 30 percent coverage is viewed as the goal for full-day places in day care centers; but this is an ambitious goal nationally in the context of 6 percent coverage at the end of the 1980s, and limited resources. Moreover, this concept of adequate coverage is premised on the availability of additional part-day places for children whose mothers work part-time, or are at home, or are cared for by grandmothers but nonetheless want and need some access to a group experience. Since 1989, the Ministry of Health has not been required to earmark the employer contributions specifically for child care. As a result, any significant expansion will depend on regional support for the development of facilities and municipal investment for operating costs. Income-related parent fees in 1990 covered about 20-25 percent of operating costs.

3. Family Support Services

During the latter part of the 1980s there began to emerge a series of new initiatives. Linked to the day care centers, these developments suggest the formation of a more extensive system of child and family services focused on meeting a broader range of child and family needs than just the need for child care when mothers work. The objective is to provide a diversity of group experiences in order to meet the varied needs of very young children and the preferences of parents who might not want to participate in a formal day care center or in a full-day program - and to do it at much lower costs.

Influenced by French and Italian researchers and the experience of a 1984 OECD expert seminar,[6] a group of leading child development researchers, child care policy and program experts, and forward-thinking government officials, seeing themselves as working for the improvement of child well-being rather than just the improvement of child care, have taken a new and different approach. They see their agenda as: improving the conditions of childhood; responding to social change and changes in family structure and gender roles; facilitating the new interest in educational reform; trying to be sensitive to the needs of parents who have limited knowledge of parenting; and most of all responding to the needs - and rights - of children.

The result is a new concept of a diversified system of child and family services for the under-3s and their families, a system that includes child care centers as one component but adds to it a variety of other types of group experiences for children with different needs. These are children whose parents are not in the labor force or who work part-time, children cared for by grandparents and other relatives and non-relatives. These children need different types of programs.

The new programs are designed for parents and children, as well as for grandparents and other caregivers; and they are designed to be used part-day or even irregularly, to supply the kinds of group experiences that are essential for good child development. The entire concept is focused on meeting the needs of children first, and second on the needs of mothers or parents. These new developments are seen as providing opportunities for parents and other caregivers to: exchange experiences and concerns with other parents; obtain expert information and guidance from professionals if they wish; obtain information, help and support in their parenting role; and ultimately, to contribute to parents' socialization and education as well as that of their children, through peer interaction and interaction with staff.

Included among these new types of programs are part-day centers, part-week centers, mother/toddler groups, and a variety of other flexible forms of child care and child and parent groups. None of this is being proposed as an alternative to or substitute for existing "traditional" good quality *Asilo Nido* (which still are viewed as an essential service for the children of working parents) but rather as a supplement to and extension of these programs.

Musatti, one of the researchers helping to shape these developments, has found from her research that mothers' educational status (college or more) and employment status (professional) are more highly correlated with greater use of day care than mothers' paid employment status or the availability of grandmothers as caregivers. Furthermore, her research reveals that children from better off families are the most likely to be provided by their parents with intellectual and social stimulation and are also the children most likely to be in a day care center and to benefit from the quality of care that is provided in these programs, and the experience of being with other children. These children then end up better prepared for preschool - and later for primary school, as well. In contrast, the children who come from families with fewer resources, whose mothers have more limited education and lower status jobs and are likely to have less knowledge about child development, are the ones most likely to be in informal child care and to be in situations where they will receive limited stimulation. They are likely, also, to be less well prepared for pre and primary school. This is a real problem for the children and for their subsequent functioning in school.

There is a strong conviction among these child development researchers that a one-year fully paid maternity/parental leave following childbirth (or adoption) is important, but that rather than extending the leave longer, what is important for the children is for there to be a diversity of supplementary experiences available to those whose mothers are at home, or whose mothers work part-time, or who have at-home relative or nonrelative caregivers. They are convinced that given small family size and the paucity of children in neighborhoods, the social isolation of many of these mothers - and their children - can be devastating. Supplementary and supportive group experiences are essential. They need not be full day, and they need not be limited to the children; but they do need to provide some opportunity for children to interact with other children separate from their mothers, and mothers-parents-caregivers to interact with one another and their children and staff. Wherever these new types of centers are opened there has been enormously enthusiastic response by mothers and grandmothers; and even some fathers have participated, enabled to do so because of the greater flexibility of the programs.

Although these child development/child care leaders would like to see the *Asilo Nido* turned into a universal counterpart to the *Scuola Materna*, they recognize that current resources make this impossible. What can be done instead, however, is to expand the range of offerings beyond the traditional day care centers in order to make some of this experience available to a wider range of children including those who do not have full-time working mothers.

The pattern now emerging in the north and central regions is:

- the *Asilo Nido* or day care center as historically and traditionally used as a full-day, five-day a week program;
- expanded centers that will include part-day programs and part-week programs;
- the opening of day care center playgrounds and other outdoor facilities to children from the community;
- new part-time, part-day programs such as mother/toddler programs and "Time for the Family" (Milan), that are oriented to parents and caregivers as well as to children;
- close linkages between child care centers of all types, the preschool programs, primary schools, health care services, and social services.
- special emphases on improving quality;
- greater access to poor and immigrant families.

The aim is for complete coverage of all children under age three (as now exists for the 3-6 year olds) but not all in a full-day program. A related aim is to establish a cluster of universal services that will link children and families as necessary with social services; but not specifically services for children or families with problems.

Unfortunately, these developments are too recent for there to be any outcome data. No longitudinal studies are planned, nor are any rigorous evaluations. There are some studies of school impacts however which strongly suggest positive impacts.[7]

Nonetheless, government officials and the public generally are becoming increasingly aware of the potential for learning that very young children have and how this needs to be nurtured. Municipalities are recognizing that child care services enhance the social fabric and strengthen the civil society. Resources are limited and the proposed strategy is sensitive to this constraint. But there is growing recognition of the value of such an investment.

4. Child and Family Health Care and Social Services

Until January 1, 1993 Italy had a universal national health service, established in 1978 as part of its social reforms in the 1970s. It is now income-tested and the expectation is that about one-third of the population will no longer qualify for National Health Insurance (despite universal coverage for children up to age 12 and the elderly) because their income will be above the income ceiling.

Both an emphasis on decentralization (and regionalization) and on deinstitutionalization are reflected in the health service and its local service delivery system. Health planning and financing are carried out at the national level but the delivery system is managed at regional and local levels. Social services, which are closely linked to health care and in some regions such as Emilia delivered at the same location, are not planned for nationally; however, Emilia, is now trying to develop a regional social services plan to parallel its regional health plan. One issue not yet resolved is that the health care system even now will serve most of the people while the social services serve only a "marginalized" population, usually poor.

The social services have a tripartite structure with one part serving the elderly, a second that is targeted on adults and is problem-focused (disability, drugs, corrections) and a third that is oriented to children and their families. This last component is closely linked to the local child and family health services.

There are three different types of local health centers for children and their families in Emilia Romagna:

- Family Counseling Centers are targeted on women and couples and provide family planning services, contraceptive counseling and devices, counseling for women during pregnancy, women's health services, and couple counseling. These centers also provide courses on sex education, courses for parents with regard to pregnancy and childbirth, and a midwife who remains with the pregnant woman throughout her pregnancy and immediately after. It is this midwife who provides information to the pediatric nurse in the infant and child center who, in turn, makes the initial case finding home visit once baby and mother return home. Thus, there is an effort at keeping a close connection between the prenatal care received by the mother and the postnatal care received by both mother and child subsequently.

- Infant and Child Centers are targeted on the very young child, under age 3, but also serve some older children including adolescents. These Centers provide preventive health care (postnatal care for women, well-baby care, vaccinations, early screening and diagnostic testing, etc). They also provide a home visiting service for chronically-ill children and a home visiting service immediately following childbirth by a pediatric nurse. She assesses the baby, notes whether the child appears to be developing properly, assesses the parents in their new role and the home.

If all seems adequate then there is no subsequent follow up or visit. Otherwise she may make a second visit and if she continues to have some concerns may provide the parents with a referral to a variety of other services. The nurse also provides the mother with a little booklet that lists the vaccinations that are required and the dates that they should be done, a list of local pediatricians whom the mother can call on for care, helps the mother in the initial medical and social care of the child, and gives the mother a first appointment for the baby's first vaccination at the clinic. This is a universal program, carried out with regard to all the children born in the community. The hospital provides the information to the Infant and Child Center and to the midwife. The pediatric nurse is immediately provided with information and carries out her visits. Thus the initial referrals can come either through the midwife in the Family Counseling Center or though the hospital giving information to the local district office.

- The Child and Family Centers are recently established community-based services which are oriented to the socialization and support of families with children. In particular, these Centers provide counseling and education for parents as regards child rearing, recruit families to help other families in difficulties, especially with regard to childcare in the hours not covered by existing childcare services (evenings, nights, holidays), and carry out special programs for parent education, family support, help for immigrant families and families with handicapped children. The Family Centers are staffed not only by social workers, educators, teachers and psychologists, but also by volunteers who receive special in-service training. At present there are about ten of these Centers, which were established according to a recent regional law (no. 27/1989). No formal evaluations of these Centers are planned as yet.

CONTEXT

1. Demography

Italy has a population of 57.6 million (1992), slightly larger than Britain, making it the second largest country in the EU after Germany. Its total population is likely to remain level or even decline over the next few years. Forty-three percent of its population lives in the north, 19 percent in the central region, and the remainder in the south and islands. Italy has a rapidly aging population, especially in the north. Only 15 percent of the total population is under 15 while the same proportion is aged 65 and older, making Italy closer demographically to Germany than to any other country. In 1988 immigration was insignificant, less than 1 percent of the total population; however, in 1990 and 1991 immigration pressures began to increase. Emigration is no longer an important phenomenon.

After peaking in 1972, marriage rates in Italy have been declining dramatically. In 1989, its marriage rate (5.4) was well below the EU (then EC) average, below that of Denmark, Finland, Germany, and UK, and far below the U.S. Although its divorce rate remains very low, its legal separation rate is high. And if its out-of-wedlock birth rate and proportion of families headed by single mothers (5.5 percent) is lower than all the other EU countries (and far lower than the U.S.), its total fertility rate (1.29) is dramatically low as well. Cohabitation is growing among childless couples but overall it is a very small phenomenon in Italy constituting only .1 percent of families with children.

In the mid-1980s there was still little discussion in Italy about single mothers. The official figures suggest it is still a very small phenomenon but some believe that it is really larger and getting still larger - but not yet visible. As a result of the legalization of abortion in 1978, the numbers of unwed mothers declined in 1980s. Italy has a high rate of abortion; and it is relatively easy to obtain although it is still stigmatized in some parts of the country. Despite the legalization of divorce in 1971, it remains difficult to obtain. The divorce rate is low and those who get a divorce tend to be the better off. Although joint custody is now permitted, by far most divorces result in the mother retaining custody of the children.

Italian poverty rates were below the EC average in 1980 but at the average in 1985.[8] Nonetheless, when the Italian poverty commission issued its report, single mothers were not listed as an especially vulnerable group, perhaps because they are such a small group. Old people, the unemployed, and large families with four or more children are at greatest risk of poverty. Single-parent families were not identified as a special concern, although they appear now to be considered among the "at risk" groups. The conventional wisdom is that single mothers have all the expected problems - time poverty, income poverty, stress - but no data are available; there has been little research carried out on single-parent families in Italy.

Of the one-parent families, 85 percent are female headed; and of these almost half are widowed, close to 40 percent are separated, 12 percent unwed, and only 7 percent divorced. These families contain about 12 percent of all children under 18, however, only about 15 percent are under age 7. The widowed status in Italy is protected and an honorable status; other types of single mothers are still stigmatized.

Female labor force participation rates of women with children under 18 in 1988 were 44 percent, lower than Denmark, Finland, France, Germany, UK, and the U.S., but at about the average for the EU. Sixty-seven percent of single mothers, far more than in Britain, and 38 percent of married mothers are in the labor force. Rates are higher for well educated women (82 percent of single mothers and 61 percent of married mothers with a university education). There are no systematic data regarding women's labor force patterns by age of child or by types of single parent status.

Rates for women with children under age 3, at 45 percent, were higher than those in Germany (39.7 percent) and Britain (36.9 percent) but lower than the other countries discussed here. Rates for lone mothers with children under age three, at 68 percent, are far higher than those in the U.S., Germany, and the UK, but similar to France and lower than Denmark and Finland. A full comparison with the other EU countries is not possible since the data are not available. The rapid pattern of growth in labor force participation among women aged 25 - 34 between 1970 and 1988 is very similar to that of Germany. In general, the realities of work in Italy affect the pattern of female labor force participation. Most working women work in the public sector (education, child care, social work, nursing). Most work full time. Moreover, most opportunities are limited to the young. Leaving a position having once achieved a good job, it is very difficult to return. As a result, most young women, once in a good job, are unlikely to leave. Women constitute about 36% of the labor force and a higher proportion of the unemployed than men; the highest rates of labor force participation are among the 20-45 year olds, those also at the peak of their childbearing years.

2. Expenditures

Italy is at the OECD average regarding social expenditures as a percentage of GDP, slightly below the average in its growth of real social expenditures. Its overall governmental expenditures, however, increased more than the average as a proportion of GDP, between 1960 and 1985 and its social expenditures were a higher proportion of government expenditures between 1960 and 1980 but declined to the average by 1985.

Family benefits were an important part of Italy's social expenditures in the 1950s, constituting about the same share of social expenditures as pensions, each constituting about 40 percent of expenditures on income transfers. From then on, however, family benefits declined dramatically as a proportion of social expenditures, from 29 percent in 1960 to 13 percent in 1975 and 5 percent in 1984, well below the OECD average. During the same years, in contrast, pensions increased their share

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almost as dramatically as the share allocated to family benefits declined, rising from 40 to 80 percent of income transfer expenditures. Education and health expenditures continued to increase during these years, education during the 1950s and 1960s in particular and health throughout the whole period.

Between 1960 and 1975, during the so-called golden years of social policy, while the OECD average annual growth rate of family benefits was 5.3 percent, the rate in Italy was -0.5; only Australia and Canada had lower rates of growth during these years. And between 1975 and 1984, when the OECD annual growth rate remained stable (5.2 percent) Italy's benefits increased by only 1.3 percent, leaving it among the four countries with the lowest growth rates again, and the lowest ranking country of all when both periods are combined. Italy was at the OECD average for health and education expenditures as a share of GDP, well above the average with regard to pensions, began above average regarding family benefits but steadily lost ground especially in the post 1975 period.

Family benefits and maternity leaves combined, for the EU countries, placed Italy at the EU average at the end of the 1970s but at the bottom of the heap by the mid 1980s. Family benefits declined as a portion of gross wages in Italy between 1975 and 1985 while wages increased and family benefits declined in real value, and declined even further as a portion of disposable income as well.

Not all the changes in the value of family allowances and pensions can be attributed to demographic changes. Some growth in both benefits occurred because of the increased categories of beneficiaries. Family allowances gradually were expanded to cover farmers, domestic workers, those receiving unemployment benefits and those receiving pensions, and most recently, the self employed. Pensions covered farmers and the self employed. But pensions increased their share still more because the benefit level (the minimum benefit) was raised, and unlike family allowances, the benefit was made earnings-related (1968) and indexed (1971). In 1979, income transfers constituted about 16 percent of family income, and one-third of all families in Italy received at least one-third of their income from transfer payments. The poverty that continued to exist nevertheless, was due to low wages, large families, unemployment, some among the elderly who only qualified for the minimum (low) pension, and the absence of any guaranteed minimum income in the context of the close linkage of social benefits to employment.

3. The Politics of Social and Family Policy

The limited and fragmented Italian welfare state is the result of a strong Catholic tradition coupled with a weak national government, on the one hand, and strong regional governments coupled with an industrialized and affluent north with left political parties in power at the regional and local level, on the other. As in other countries, the more generous family policies of the north were also the result of overall demographic and social changes, in particular the declining birth rates and the rising female labor force participation rates, but these were not the only factors in affecting social reform.

In contrast to much of Europe, Italy emerged from World War II a sharply divided country politically. Rather than supporting national solidarity, Italy had to reconstruct some sense of national purpose, and this was difficult to accomplish and took time. Italy had to rebuild not only its economic infrastructure but also its social fabric. Post World War II reforms in Italy were nowhere near the scale and scope of other European countries, and by the end of the 1940s "The welfare issue soon moved back to the periphery of political debate and competition, with social policy remaining for two decades a fragmented arena of marginal adjustments, additive expansions and clientalistic exchanges."[9]

The original post World War II national institutional welfare framework included a social insurance system, limited to employees, a health system with a largely private delivery system until the reforms of the 1970s, and a limited and discretionary social assistance program.

From 1968 through the 1970s the Italian welfare state changed significantly, in response to social and demographic change, social conflicts, union and left party political pressures, and a growing secularism. The result, at the end of the 1970s, was a very different welfare state: decentralized, secular, and far more "modern". Social insurance benefits were more generous, wage related, and indexed. A national health insurance system was established with the regions and localities responsible for the delivery of services and individuals still able to use their own physicians. A new national system of public preschools was established, the public sector emerged as dominant in the provision of preschool education, and a role for the public sector in child care services for the very young was established as well. Cash family benefits declined in significance and value and became more targeted at the same time as child and family related services increased in value and became more universal. And social policy emerged more clearly as the role of government, even if divided between national and regional levels, while the church's role was increasingly constrained.

The 1970s were a turning point. More specifically, significant demographic changes occurred, especially the decline in fertility rates, family size, marriage rates and the increase in female labor force participation rates. At the same time, regionalization of several family-related policies occurred, leaving the national government responsible for financial and economic problems, general guidelines and framework laws, but not responsive to social change and families' real needs. And regional and local governments were made responsible for services for children but given little authority (no right to tax) or resources for financial support.

Major family law and policies changed during the 1970s, beginning with the establishment of a direct national government role in the development and management of preschools in 1968. These changes followed by almost a decade the international social reform movement that occurred in the 1960s in most of the industrialized world. Among the most important developments were:

- 1970 - The introduction of divorce.
- 1971 - The enactment of legislation launching a development plan throughout the nation for day care centers for the 0-3s.
- 1971 - The enactment of a law on maternity leave (1977 law gives men some rights as well).
- 1974 - Family law reform aimed at providing equality between husbands and wives and defining parental authority concerning children.
- 1974 - Family participation in school management.
- 1975 - The establishment of Family Counseling Centers and family and maternity services (1975).
- 1977 - The enactment of a law establishing equality of treatment between men and women in the labor market.
- 1978 - The enactment of a law legalizing abortion.

Of some interest, we would note, just at the time that President Nixon vetoed the comprehensive day care legislation (1971), Italy took its major step forward in social policy nationally, enacting both national day care legislation and national maternity and parenting legislation.

Nonetheless, Ghedini complains that although Italy is among the more advanced European countries with regard to the rights assigned to children and the principles of social policy, it has nonetheless failed in the development of and the implementation of coherent national child and family policies, and failed in particular in the development of a coherent national policy toward the under-3s. Corsaro and Emiliani, too, stress that Italian national legislation sets forth goals and positions but does not deal with implementation. Thus, the national government enunciates principles, but where regions and localities are then given responsibility for actual implementation, there is no effort on the part of the national government to enforce the policies. A weak central government may delineate worthwhile policies, but implementation depends on the decisions made at regional and local levels, and often serve to undermine national principals. The result is enormous differences across regions, and inadequate support for what the regions are expected to do. Finally, philosophical inconsistences emerge as well, with the cash family benefits - the family allowances - increasingly meager and targeted and the services increasingly generous and universal.

ON THE GROUND

CHILD CARE, FAMILY SUPPORT, AND HEALTH CARE

1. Child Care

The Italian child care system includes the *Scuola Materna* for children aged 3 - 6, and the *Asilo Nido* serving those aged 3 months (but largely 9 months) to 3 years. The *Scuole Materne* serve about 90 percent of the age group nationally while the *Asili Nidi* serve only about 6 percent, with wide regional variations ranging from 20 percent in Emilia Romagna in the north, to 2 percent in the islands. Although the expansion of the *Scuole Materne* in the 1980s is clearly related to the growth in female labor force participation, the development is attributable more to a view of this program as essential for child socialization and education. In contrast, the *Asili Nido* is viewed primarily as a service providing care for the children of working mothers.

Reggio Emilia, a wealthy, medium-sized city in the north-central part of Italy and center of the Italian "economic miracle", is the home of an internationally renown *Scuola Materna* called the Infant School (Scuola del Infanzia) Diana.[10] There are 20 similar preschools in this city where all children aged 3 - 6 are enrolled either in a municipal preschool school (47 percent), a national preschool (13 percent) or in a publicly funded, private, church-related preschool (40 percent).

"Diana" is located in a beautiful park, surrounded by many other public facilities including two theaters, a primary school, and a middle school. It is known as an extraordinary example of a public preschool program and has been visited by more than 8,000 foreign experts over the last decade. It serves seventy-five children aged 3-6 in three age-specific groups of twenty-five children each, with each group staffed by two teachers and an extra teacher brought in to help with three handicapped children. There is also a special teacher who is in charge of the "studio" or art workshop and who has responsibility for the creative arts program that is one of the unusual features of this program and the programs in this city generally.

The facility itself is even more beautiful than the surroundings, with an entry area opening on to a large room with a dramatically high arched ceiling. The room functions as a kind of village "*piazza*" or square for the school where all the children play together at the beginning and end of the day (before 9:00 am and after 4:00 PM); small groups of children make special use of it at other times. Part of the room is divided into several specialized play areas including a play store, several climbing and tunnel-like toys for very active physical play, a puppet theater.

Off the square are three rooms, one for each of the groups (each further sub-divided as will be explained below), and various administrative offices. At the rear of the square is a glass wall with a doorway opening on to the art workshop, where there are various tables and shelves set up for play with clay, wood, plastic, wire, paints, etc., and a special teacher who works with the other teachers as well as with the children from each of the groups.

Children arrive at the preschool between 7:30 and 9:00 AM and engage in free play in the village square, where they may also have breakfast. They depart between 4:00 and 6:30 PM, and the ones who remain beyond 4:00 again play together in the square, under the supervision of two or more teachers, depending on the size of the group.

At 9:00 AM each group assembles in its own room with its teachers and decides what they will do that day within the context of their overall project (see below). Each group has a name, and each group room is further subdivided into three rooms, one for active play (the very active physical play goes on in the "square", however), one for quiet (and more individualized) play, and one for resting or sleeping. Each group is also divided into three smaller groups and they, in turn, decide what part of the overall project they will work on that day. The children are actively involved in planning each day's activities as well as in planning subsequent activities and choosing the "theme" for the year.

In the large room, where much of the activity goes on, there are child-sized tables and chairs and here is where the children eat together. For example, in the 3 year olds' room, the bulletin board announced the "theme" for the group for the year. In the "active" room, three children worked at a child-sized table with clay; one teacher was with them, talking to the children. At another table, three children worked with clay and wire and a second teacher was helping one of them. At a third table, two children were using crayons and colored markers and at a fourth, two children were playing at a table that was lit from below. The children had colored pieces of plastic and were placing them on the table to create an attractive design. Throughout the room there was constant verbal interaction. The children were talking to one another and to the staff, and the teachers were initiating the discussion or responding. In the "quiet" room, two children were at easels, concentrating on their own paintings, in contrast to the children who were working on a group mural in the larger room.

The 4 year olds' "theme" was "trees and forests". Some children were constructing trees out of wire and clay, scotch tape and staples. Others, at another table, were painting or using colored markers to create a mural. Six children were at a table with a teacher who was teaching them about light and shadows through the use of a flexible light that she and another child moved in different directions, and a small wooden horse. The children took turns guessing - and then later analyzing - where the horse's shadow would fall as the light was moved.

The 5 year olds were still more independent. Several were working with the art teacher in her studio. Others were outside playing. Three were in a small room listening to music and several others were playing games ranging from checkers to a computer game. Still others were playing at the "store" in the village square, learning number concepts by buying and selling items at the store, discussing how they should be priced, and so forth. One child was the shop keeper. Two others were "workers" and "clerks" and three played at being parents going shopping. Two of the teachers stopped by to "shop" as well, all using play money to make their purchases.

There is here: acute awareness of how children develop, programming to enhance each developmental state; great emphasis on documenting on film, in writing, in wall-hangings and artwork, what the children do; two-way sharing between center and home on what the children are doing. The center - family relationship is an active partnership.

The program stresses family involvement, parent participation, and community-based management. Parents meet with staff on a one-to-one basis frequently. There are, in addition, regular parent group meetings and parents help out in a variety of ways. Of particular importance, by law parents must constitute at least half the members of the preschool's Advisory Board. Parent-representatives are elected by the parents to the board for a two-year term. During the 1992-93 academic year, the Advisory Board met five times plus several additional meetings for specific projects. The Board helps set fees, raises funds for special activities, acts as liaison between the school and the local government council that supervises the school, and helps to choose among suggested special activities for the different groups. The parents are not involved in hiring staff, however.

The teaching staff get their jobs through the usual civil service examinations for early childhood teachers. Many have university degrees in something like early childhood education and there is a big emphasis on in-service training as well. Staff meet together weekly along with the cooks and cleaning staff, to discuss the curriculum, how the week has gone, and to plan for the next week. Staff document daily what each child has done in his group and this information is shared with parents and other staff. "Team teaching" is stressed also, as a way to reduce traditional staff isolation.

The basic curriculum and educational philosophy is the same throughout the municipality but the curriculum is implemented in an individualized fashion at each preschool. This implementation reflects the particular style, training, and orientation of the coordinator, staff, parents, and the particular group of children enrolled at the school each year. The overall concept is that if the *nidi* function well, and the *Scuole Materne* function well, children will be prepared for formal schooling, and what is more important, will be able to cope with the less satisfactory arrangements (less individualized) in primary school.

The program is funded by the municipality but some funds come to the municipality from the region and the national government. The budget is set by the municipality in relation to the numbers of children served. The core program (7:30 AM to 4:00 PM) is free to all children while the supplementary program (4:00 - 6:30 PM) and the meals are paid for at income related fees.

Thirty-eight percent of the children who enter the Scuola del Infanzia come from the *Asilo Nido*.

One exemplary *Asilo Nido* is located in Modena, another wealthy, medium-sized city situated in the same region. Characteristic of this region generally, most of the cities are wealthy, have high rates of female labor force participation (over 60 percent of the women with preschool aged children are in the labor force, like the U.S.), and politically left governments.

The *Asili Nidi* in Modena follow the standard pattern: They are open five days a week, except for holidays (Christmas and Easter), from 7:30 AM to 6:30 PM, 10 months a year (they close in

July and August, although sometimes one center in the city may remain open in July).

Children arrive between 7:30 and 9:00 AM and depart between 4:00 and 6:30 PM. The long hours are available only to those children whose parents work such hours and can provide documentation that attests to this. For children who do not need a full-day service (at least 9:00 AM to 4:00 PM), or for parents who want a group program for their very young children and are not themselves in the labor force, several new models have been developed including part-day *nidi*, play centers for children and adults, small programs serving 7 - 10 children rather than the 15 (minimum) to 60 (more usual) in the traditional *nidi*, play groups serving children on a part-time, part-day, or part-week basis, and outdoor programs attached to an existing *nido*, serving children from the community who are not enrolled in a *nido*. The current policy is to expand existing coverage for the under 3s in a diversified delivery system targeted on all children, both those with working parents and those with at-home parents.

In Modena, there are 16 "traditional" *nidi*, three play Centers which will soon be expanded to seven and two open nidi which are also expected to increase to 7 (one for each neighborhood). Twenty-five percent of the 0-3s are in either the traditional *nidi* or the part-day *nidi*. Since most children do not participate in the *nidi* until they are 9 months old (because working mothers can obtain maternity/parental leaves for 9 months after birth) coverage is really even more extensive than 25 percent for the 1-2 year olds. Nonetheless, if one combined full-time working women with children under three with part-time working mothers and full-time students, about 70 percent of the children under 3 would need places in a *nido*. Waiting lists for all types of *nidi* are quite long.

As is typical of Italy generally, almost all the *nidi* (97 percent nationally) are public, operated by the municipalities, and in this region funded by the region as well as the municipality. Although under the health ministry at the national level, they are under educational auspices here (as in several other regions in Italy).

Children of working parents have the first priority for enrollment. Parent fees are income-related but at most cover 25 percent of the program's operating costs in Modena (and in Milan);

"Cividale" began as a *scuola materna* but in 1985 was transformed into an *Asilo Nido*, serving 48 children in three groups of 10 - 18 children each. The groups are organized by age, as they are in almost all the centers in Italy. There are at least two teachers for each group, with a third for the middle group who fills in in the other groups if a teacher is absent. Thus, overall, there is one teacher to six children aged about 9 months to almost three years, one cook, and three helpers who also clean.

The program begins each year in September with a new entering class of babies. The first week is just for staff to prepare for the year. From then to mid October children are phased in, about three or four each week.

The building is a low-rise, half one story and half two stories. There is a large open area off the entrance (the village square concept, in a somewhat smaller form) and near the entrance are strollers and baby carriages. Six children and a teacher were sitting on a rug off to one side, playing together. There was a climbing area in the back of the room and several small tables where a few children were painting. Each group had its own smaller room located off the central "square", and each of these was subdivided into an area for play with tables and chairs, a second area for quite play and eating, and a third area for sleeping. The rooms were colorful and spacious. There is also an office for a pediatrician who holds a health clinic at the center once a week for the children in the *nidi*. There is a small kitchen as well and a room for washers and dryers.

Children have their own cubbies, with their names or pictures on them, for putting their outer clothes in when they arrive each day, and for keeping a change of clothes as well. Each group has its own menu posted at the entrance to the group room where parents can see what their child has eaten that day. The children are deliberately introduced to different types of foods, including those not served at home. At the same time, there is great sensitivity to cultural differences around food, special diets, etc. Children have the same crib each day, when they rest; and they have their own transitional objects as well - a stuffed animal, a blanket, or a piece of a blanket.

Almost all the children have working mothers, although as is typical, there are a few children with special needs including one handicapped child (with Down's Syndrome). There is great stress in Italy on mainstreaming handicapped children.

In the room for the under-1s, there was space for crawling, low mirrors to look at oneself, a place for water play. Changing tables, in a separate room, had windows at a level that children could look through to the playing area and watch the other children while they were changed and cleaned.

In the room for the 1 and 2 year olds there was more equipment for active physical play including climbing toys and steps, and more opportunity for drawing and painting as well as water play. There were also low windows between the rooms, one way mirrors for adults to observe, and low mirrors for children to look at themselves.

Nidi staff here have completed at least a three-year post-high school vocational training course or a fourth (or fifth) special year course in early childhood education. Staff work thirty-six hours a week, thirty hours with the children and six hours in in-service training, staff and parent meetings, planning. Staff turnover is very low, in part because these are civil service jobs and are relatively well paid and secure, with good benefits. *Nidi* staff are paid about the same as *Scuole Materne* teachers and only a little less than an elementary school teacher.

The second floor of this facility has a part-time play center (sometimes referred to as a family center or a mother/toddler program) for the under 3s. Children attend one of two sessions, either a morning session or an afternoon session.

The morning session, from 7:00 AM to 1:15 PM, is for fifteen children whose parents have requested this service. The children range in age from 18 months to 3 years and are cared for in an age-integrated group. Fees are income-related.

The afternoon session is from 3:00 - 6:00 PM, for 18 children of the same age as the morning program, who come two to four afternoons a week with their mothers (or other caregivers), for a play group experience. It is free. It is not a drop-in center. Mothers must come on regularly scheduled afternoons and must remain with their children. Every two weeks a parent meeting is held and issues of particular concern to the parents (mothers) are addressed in a meeting led by a professional. A list of issues that have been addressed thus far this year is posted near the entrance and added to after each meeting. Thus far, the issues include: sleeping problems; eating problems; the role of fathers; the role of grandparents; the birth of a second child.

Parents apply for places in this program just as they do for the *nidi*, making formal application in the local district office. Parents have to provide proof of the child's age, vaccinations, and a picture. Here, too, demand far exceeds supply. There are fifty-four places in these play groups in Modena and 200 applications. Although priority is given to children from lone mother families and handicapped children who were not admitted to the full or part-day *nidi*, most children are served on a first come first served basis

Although the space is small it is handled in the same way as the full day *nido* downstairs: one room is for active play; a second is for role playing activities including playing house, a third room has small tables and chairs, for both drawing and painting as well as snacks. There is no resting room because the children are there only for part of the day and neither sleep or eat a full meal at the center.

The morning program has two full-time teachers and one part-time teacher. The afternoon session has one full-time teacher plus part-time support staff and parent volunteers. Staff have the same kind of training as for the full day *nido* and two had at least as much experience, one twelve years and the other fifteen years of teaching in the *nidi*.

In general, the developments in Modena, Reggio Emilia, Bologna, Parma and Pistoia are very influential in Italy. There is great interest in their philosophy and curriculum, their emphasis on socialization, education and development as an integral part of good child care, on verbal interaction, on close links (integration) between the *Asili Nidi* and the *Scuole Materne* and between the *Scuole Materne* and the primary schools. There is a growing emphasis on locating a traditional *nido*, a part day *nido*, a child and family center, a *scuola materna*, and an open play area for all children close together.

Asili Nidi in Milan vary in size from 30 to 60 children; by regional law, none may be larger. Enrollment is premised on the assumption that about 10 percent of the children enrolled will be absent at any one time, therefore maximum enrollment is sixty-six for a sixty place center. In a facility with sixty children, there is a coordinator, a director, in U.S. terms, but with less authority, twelve educators or teachers, one cook, and five others who are aides, cleaners, etc. Children range in age in September, the beginning of the year, from 3 months to almost 3 years, although most of the youngest are about 9 months old. Despite the stated group size, many fewer children were present than the full complement; apparently, there were several babies absent because of head colds.

Centers are likely to be on one floor, with strollers and carriages near the entrance, where parents leave them when they bring their children. In one Milan center, the youngest group has 18 children under age one and four teachers. The second group has twenty-three children aged 1 - 1 1/2 and five staff. The third group has twenty-five children aged 2 -3 and four staff. They have a pediatrician on site every day from 8:30 to 11:30 who serves the children at the center as well as other children of that age in the neighborhood. (This is not a typical pattern. Usually, a pediatrician will come one or two times a week to the center.) In addition, there is a nurse who comes in two days a week, a typical pattern for these centers.

Here, too, each group has a large room, divided into three areas, with the group subdivided as well into three smaller groups. Here, also, are two smaller rooms, for quiet play and eating, and for resting and sleeping; and there is the usual changing room and toilets and sinks. Toys are taken off the shelves in the main room selectively, so that there is variation during the day. Here there are more likely to be black, north African, or Asian children.

Two babies were crawling in what looked like a very large play pen with one of the staff sitting inside as well, and another was practicing climbing stairs on a big low step ladder kind of toy. Two babies were being fed, held in the teachers' arms. Babies are fed following the pattern set at home, either at regular times or on demand, and then put down to sleep. In the sleeping room, three babies were asleep in their cribs.

There were "diaries" on the walls of the main room, near the entrance, for the mothers to read when they pick their child up at the end of the day. One note said that "Anna began to walk today and made two steps without holding on."

In the second room, for the toddlers, two little girls were choosing among several dolls on a low shelf. Several children were playing around a big low table. Others were at a sink playing with water, others were painting. Two girls and two boys were playing house in another part of the room, and near them was a doorway to the outside, the first such door we saw in visiting many Italian centers. In most, there was only the main entrance and another, but not doors to the outside from each room in the center, as one sees in Denmark, for example. In the sleeping room, there were separate cribs for each child and nearby, the usual bathroom facilities.

Lunch is different for each group, and the menu depends on the children's age. The babies always have special food. No pork is ever served in this center since they periodically have one or two Moslem children. A 2 year old little girl was there who had just come from Sri Lanka the previous year. She was talking already, and talking Italian. Her parents were especially proud since she would be ready and able to attend the *Materna* the following year.

Somewhat beyond the historical center of Milan, in a large red brick building, one side of the building is a primary school, the other is a *scuola materna* and a *micro-nido* for children aged 18 months to 3 years. The *nido* is on the main floor, has fewer children than traditional *nidi*, and does not have its own kitchen.

The entrance is spectacular - a very large room in a kind of theater format, with children and teachers using the stairs for talking, reading, playing. This main room is slightly sunken, with three steps all around it. On two sides the steps have cushions and pillows to sit on. The walls are brightly colored and there are various action toys and climbing equipment in the central area. Off this "square" is another large room with three subdivided sections for the usual activities: active play, quiet play and eating, resting, and a separate room with child-sized toilets and sinks. Adjacent is a small sitting room area where mothers sit during the child's transition into the *nido*. Here, as in other *nidi*, there is a gradual separation of mothers from children, a two week period with mothers spending decreasing time with their children or nearby. There is also a small staff room and bathroom. Meals are delivered from another nidi nearby.

The children arrive between 7:30 and 9:00 AM and leave in three groups, the hours being posted near the entrance. The first group leaves at 1:00 PM, the second between 3:30 and 4:00 PM, and the third between 4:15 and 5:30. The groups are age-integrated, each including children from 18 months to 3 years.

Staff/child ratios are 1:5 for those under 18 months and 1:8 for those 18 months to 3 years.

In this center there are two age-integrated groups of sixteen children each with three teachers each. A doctor visits two times a week. Each group is subdivided into three smaller groups, and based in their own rooms in addition to having the use of the large central area.

The central square is used for the two groups to play together in the morning before 10:00 AM and in the afternoon after 3:00 PM. In addition, sub-groups use it during the day for active physical play. Since many of these children come from quite small homes, having this large area to run and play was extraordinarily exhilarating for the children. Within the two main group rooms, several children were playing at low tables and chairs working with clay, playing with seeds. In another area they played with blocks. In still another area children were playing dress-up. There were also musical instruments, recorders, castanets and drums off to one side in the room, and two children were exploring these.

There is a shared bathroom with child-sized toilets and sinks as well as potties for the children who are not yet toilet trained, and a changing table for those still in diapers. Some children used pacifiers and one teacher was washing several and placing them, when clean, into containers with the child's name. All the children have labelled bags on hooks near the bathroom, with a change of clothes as well as cubbies near the main entrance, for their outer clothes and other changes.

In the second group, several children were napping in the resting room. Each child had his/her own mattress or sleeping bag, kept in the same place each day, with his/her own special objects to hold when resting. A staff member remained with the children while they rested or slept. In this group's main room, one corner area was partly enclosed and filled with many small brightly colored balls. Three children and a teacher were sitting in this "play pen" and playing at an imaginary sea.

The children who will attend the *materna* in the fall spend one day a week from January to July in the first group at the *materna*, to facilitate the transition. There is constant awareness of the *materna*, since the large central square where the children have their active play has a skylight across the top and the children from the *materna* can look down around the edges of the skylight, and the children from the *nido* can look up.

Ideally, in Milan, too, it is recommended that the *Asilo Nido* be located near a *Scuola Materna* and near several alternative child care centers as well: a *micro-nido;* a part day *nido;* a child and family center or family time center (a family support service). The *Scuole Materne* are never co-located with a primary school but rather with *Asili Nidi.* There is a strong emphasis on continuity between the *nidi* and the *materne* even if it the same kind of continuity does not exist between the *materne* and the primary schools.

FAMILY SUPPORT CENTERS (FAMILY CENTERS, CHILD AND FAMILY CENTERS, FAMILY TIME CENTERS)

There are ten Family Time Centers in Milan and four others that will be opened shortly in communities with a high proportion of immigrants. These centers are in addition to 90 *Asili Nidi*, 10 *micro-nidi*, and 130 *Scuole Materne*, all under the department of education in Milan (Lombardy). About 25 other Family Time centers or related programs exist in Emilia Romagna and neighboring areas.

The Family Time Centers are one of several new initiatives that have emerged in northern Italy over the past five or six years, focused primarily on providing socialization and education experiences to children under age 3 and their mothers or caretakers. The purpose of the new developments is to approximate the value and universality of the *Scuole Materne* for those children who are not eligible for formal day care centers (*Asili Nidi*). These alternative centers are designed to attract the shy, insecure, isolated mothers, as well as the young or single mothers, to offer mothers and other caretakers (child minders, grandparents) opportunity to meet one another, discuss common problems, participate in activities with their children and under the guidance of professional staff, and to offer their children opportunities for socialization, peer interaction, and cognitive stimulation. Initially, this was a demonstration program but now the city has taken it over and is establishing others elsewhere in Milan.

To participate in the program, the children have to be accompanied by a member of their family or a non-relative caretaker. The premises are designed to allow individual free play as well as large group activities. Mothers can participate in their children's activities, observe their children, read, or chat with other mothers or the staff. Participation is free, although parental contributions may be sought to buy special equipment or supplies.

One center is located in a working class housing development that includes among the residents drug addicts and others with a variety of social problems. As is usual, it serves mothers with children who are only a few months old up to 3 year olds. Some mothers are not in the labor force; some are home on maternity or parental leave; and others work part time. In general, women with children under 18 months tend to come out of their own needs while those with children that age and older come in response to their perception of the child's needs. Two or three very experienced, full-time professional staff are available in this center for each fifty children, plus the same number of part-time staff, a cleaning woman, and several volunteers from among mothers who previously participated in the program. Recently, some of these mothers have begun to organize themselves as family day care mothers, a type of caregiver that did not exist in Italy until the last few years.

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Mothers, caregivers, and children come from 9:30 or 10:00 AM to 12:30 or from 3:00 PM to 6:00 or 6:30. No lunch is served and therefore there can be no all day participation. About 150 families use this center, not all at the same time, of course. Mothers/caregivers are expected to come at least two times a week; fewer times make it more difficult for their child to adjust to the group. Most come three or four times a week and under special circumstances they may even come every day. After a period of visiting, the mother chooses either the morning or the afternoon sessions, or a combination, and is scheduled. The center's capacity is about twenty-five, thus the need for the modest scheduling. Also, they do not believe that a larger group is functional for either the mothers or the children. Mothers are not held to a fixed schedule and really can come in response to their own needs, but it is believed to be better for the children to find the same children - or at least some of the same children - whenever they attend.

The morning we visited was described as "a very quiet morning". Six children of about 9 months to 18 months were crawling around on the floor of the center with five mothers and a staff member having coffee, sitting on a couch, talking together and watching the children. A 13 month old little girl was playing with two younger boys and one older girl while two mothers sat and talked nearby. One mother was off by herself reading, but responded immediately when her child called. Another child was being read to by her mother. A grandmother sat happily watching her grandson playing with another child. Toys, low tables and chairs, books, paints were all available and in use. At the end of the morning, before the session ended, the mothers, grandmother, staff, and children gathered in a circle and led by a volunteer mother, sang songs.

Another Family Time Center is located partly in a *Scuola Materna*, where there is also a *micro-nidi* and an adjacent school. Children are divided into two groups, one for children under 20 months, and a second for those aged 20 months to 3 years. The younger group is situated in a center on the ground floor of an adjacent residential building while the second, for the "older" children, is located in the *materna* and closely integrated with it. Eighty children and their mothers are served in this center, with a maximum of 20 in any one session (and a waiting list of 45 to participate). There are three full-time staff and two part-timers. The particular focus here, too, is on mother to mother or mother to child interaction rather than on the child's activities per se - the focus of the *nidi*.

Once again there was a large center room, a cushioned area in one corner where children can play on the floor or sit and be read to or held by a mother or teacher. There are low tables and chairs for children to do painting and cut out work. There is a small kitchen area for snacks. Several mothers were sitting together and chatting.

Some see these Family Time Centers as "preventive" programs. Nonetheless, a repeated theme is that the programs are designed to serve average, normal families with children, not problem cases. They are located in a wide range of communities, middle class as well as poor and working class. There is, however, a parallel assumption that in a big city such as Milan, in some sense all families with young children have problems. Moreover, given the limitations in places, priority is given to children with special needs (handicapped, immigrant) or families with special needs (lone mother). However, the problems that tend to be the priority cases are more likely to be social or physical handicaps rather than child abuse. Cases of children who are neglected or at risk for maltreatment are more likely to be served in a full day *Asilo Nido*. The general assumption is that no more than 10-20 percent of either the *Nidi* or Family Time centers will be problem cases. There is a general conviction that a higher proportion is likely to distort the program and therefore as the 20 percent ratio is reached, the pressure for establishing a new family center become intensive.

These programs are expanding, in part because they are less expensive than the *nidi*, there are families who would not qualify for the *nidi*, and there is growing demand. There is response to this demand in part because the theory is that mothers who are more inadequate, insecure, inept, or isolated will learn from exposure to other mothers even more than they will learn from the professional staff.

A second, very important potential problem that Family Time centers deal with, is that of mother-child separation. At many *Scuole Materne*, this is viewed as a major problem for the 3 year olds entering the program, in particular for those who have not attended a *nido*. This can create problems for the child's adjustment and learning. So the Family Centers view this as one of their primary tasks. Mothers see their children playing with other children and begin to understand its value and importance. The children respond to other mothers and to staff.

A third function of the Family Time centers is to provide a substitute - or surrogate - for what was earlier provided by the extended family. Information, advice, role modeling, encouragement, concern, support are all provided here. In contrast to the U.S. focus on pathology and high risk families, their focus on average families builds on a social infrastructure that is already in place: *nidi; materna;* health services.

One evaluation study looked at mother and caretaker attitudes towards children before and after the Family Time experience, and compared children in the *Scuole Materne* who had been in the *Nidi*, in the Family Time Centers, and at home. They found that children from the *nido* integrated into the *materna* most rapidly, and those cared for only at home were third. In addition, however, they found that the mothers who had participated in the Family Time Centers were the most competent in handling the child's transition into the *materna*. As a result, the *Materne* and *Nidi* have asked the Family Time Center directors and staff to help train *Materne* and *Nidi* staff in engaging parents more. They are now studying the experience of Family Time "graduates" in the *Materne* and how their subsequent performance and behavior compare with children who have had other experiences.

A typical *Asilo Nido* in Milan serves forty-five to sixty children and has fourteen to sixteen teachers. By comparison, Family Time Centers tend to serve 150 families, with 180 children, four caregivers/teachers and two cleaning women. In addition, these centers carry a portion of the overall director's salary and of a secretary's salary. Fifteen percent of the *Nidi* costs come from the region, 15 percent from parent fees, and the remainder from the municipality. (Parents pay a fee equal to a maximum of 25 percent of costs but since fees are income-related many (20-30 percent) pay no fee and others pay much less than the 25 percent fee.) The cost of a *Nido* place was estimated at 1.8 million Lira a month in 1991. The maximum fee for a full day in care was 250,000 Lira per month ($200). In contrast, the Materna is free for all except for the meal service which costs 100,000 Lira a month ($80), but the family pays an income-related fee. Caregiver/teacher salaries are slightly under average wage, 1.3 million Lira a month as compared with an average wage of 1.8 million - about what a secondary school teacher with 10 years of experience would earn.

1. Bologna - Maternal and Child Health Services

There are three local health units in the health municipal area and each unit has three clinics located in three different districts. Often the clinics for two adjacent districts may be held in the same building. The clinics include one for women (gynecological and family planning), a pediatric clinic, and a rehabilitation clinic.

More specifically, with regard to the pediatric clinic: the clinic serves 150 children plus about 500 who are enrolled in the Asili Nidi in the district for a total of 650 a year. The hospital provides the district clinic with the names of all the children born in the district shortly after they are born. While the mother is still in the hospital, the nurse explains to her the services that will be available to her when she goes home. She gives the mother an attractive and colorful brochure describing these services. And she explains to the mother that she (the nurse) will visit her at least twice at home. After the mother returns home, within about 10 days, a "territorial" nurse, not the hospital nurse but rather what we would call a community nurse, will visit her and the baby. If the hospital staff feels there is urgent need for more rapid attention, either for medical, social, or psychological reasons, the visit will be made almost immediately. If the mother wishes, she will also have a visit from the district community obstetrician. If the visit will not occur until the 9th or 10th day, the nurse phones earlier and talks to the mother, to make sure there are no unexpected problems.

Some mothers are well acquainted with the district health office even before they give birth, because they have used the family planning and gynecological services earlier, or because they took classes there in preparation for childbirth. During pregnancy, the clinic sees only those mothers who chose to attend but after childbirth every child and mother are visited.

The purpose of the first home visit is to provide information as well as a group of essential services, related to (1) reducing the mother's sense of isolation after birth, (2) supporting the new mother/child relationship, and (3) identifying situations of risk. The mother is invited to come at regularly scheduled intervals for visits with the pediatrician at the clinic. The family may have a family doctor or even a family pediatrician, but that doctor is more likely to be focused on the child's physical development and less on the range of services provided by the clinic. The clinic pediatric service is viewed more as a "preventive" and "well-baby" service, while the family pediatrician is more focused on treatment.

At the first visit, the nurse assesses the child, the mother, the mother-child relationship and the home (and the parent's relationship if the father is at home).

If there are excessive anxieties, depression, or special economic or social problems, the nurse will establish contact with social services, a psychologist, family services, a physician, as needed. Before the visit is over, the nurse and mother plan for a second visit generally one week later. If there are special reasons, still more visits may be made at home.

In the child's third month the mothers come to the pediatric clinic for the child's first set of vaccinations. Almost all mothers (99 percent) come to the clinic for these rather than to their family pediatrician. If the mother does not come for that visit, the district nurse will phone her to remind her and may even make another home visit to assess the situation if the mother still does not bring the baby in.

Regular "preventive" check-ups are carried out at the clinic as follows: one month after birth; two months; either the third or fourth month; either fifth or sixth month; either seventh or eighth month; either ninth or tenth month; twelfth month; eighteenth month; twenty-fourth month; thirtieth month; and thirty-sixth month.

Seventy percent of the children born in the district will be followed in the clinic until the child is 3 and enters the Scuola Materna. The proportion is even higher for the first year. Then the pediatrician for the *Materna* takes over responsibility. The pediatric clinic also has responsibility. The pediatric district clinic also has responsibility for child health care in the *Nidi* as well. The 30 percent of the under 3s who are not seen in the clinic will be seen by the family's own pediatrician, whose care is paid for by the family but reimbursed through the national health insurance system. The clinic pediatrician, as indicated, emphasizes well-baby care, prevention and services for handicapped children but also makes any needed referrals to specialists. The nurse is the most important link between the families and the clinic. Immigrant families have a special service in the local health unit that focuses on them in particular. The clinics in this city are neither crowded nor chaotic, but low key in atmosphere.

CONCLUSION

Italy has no explicit family policy, nor a generous or coherent social policy. Its social policies are more oriented toward children than families, and toward low-income and vulnerable children rather than all children. Nonetheless, it has some significant universal policies (maternity and parenting policies and extensive preschool programs for 3-6 year olds), along side of its income-tested family allowances, health insurance, and infant and toddler programs. Its weak central government and strong regional governments further exacerbate its social policy problems, leaving the northern, wealthier regions and municipalities far better off than the south. Political fragmentation, regional and local government power, and church/state tensions create even more problems. There is creativity and social innovation, but it is limited to particular regions and particular programs.

To conclude, as Flora points out, the behavior of Italian political parties has been directed less by ideology than by the need to form coalitions in order to survive. The fragmented and ideologically divided coalitions make it impossible for a party to promote and implement its own social policy. The Italian welfare state has developed through a proliferation of minor laws for selected problems and clients which a single party wanted to pass and no other party had a specific interest in opposing.

NOTES

1 For the history of child care programs, both the *Scuola Materna* and the *Asilo Nido*, see Filameno Pistillo in Patricia Olmsted and David Weickart, eds. How Nations Serve Young Children (Hillsdale, NJ: Lawrence Erlbaum, 1989); and William Corsaro and Francesca Emiliani, in Michael Lamb et al, eds. Child Care in Context (Ypsilanti, MI: High Scope Press, 1991).

2 Patrizia Ghedini, Child Care in Italy (Brussels: European Economic Communities, 1987), p. 251.

3 Ibid., p. 114.

4 Patrizia Ghedini, "Methods of Child Upbringing in Europe Today - Italy", 1989.

5 Ibid., p. 57.

6 Alain Norvez, De La Naissance a l'École (Paris: INED, 1990); Tullia Musatti, La Gironata Sel Mio Bambino (Bologna: Il Mulino, 1992).

7 Luigi Anolli and Susanna Mantovani, Tempo per la Famiglie. Reports prepared for Bernard Van Leer Foundation (Milan: Tempo per la Famiglie, processed, undated).

8 Using a relative measure of poverty, the EC poverty rate for 1980 at 40 percent of median income was 8.5 percent and 7.9 percent in 1985. Using a 50 percent of median income measure, the rates were 15.1 percent in 1980 and 14.8 percent in 1985. Final Report of the Second European Poverty Programme (1985-1989).

9 Peter Flora, ed. Growth to Limits: The Western European Welfare State Since World War II (Berlin: Walter de Gruyter, Vol. I, 1988), p. 390.

10 *Scuola di Infanza* is the term for a municipality-operated *Scuola Materna* while the latter is the term for the national preschools, and tends to be used generically, internationally.

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UNDER-3s IN THE UNITED KINGDOM

A CASE STUDY

Table of Contents

PAGE

INTRODUCTION ....UK 3

THE U.K. FAMILY - OR CHILD - BENEFIT SYSTEM TODAY......UK 4

1. The Major Family Benefits.....................UK 4
2. The History of Family Allowances/Child Benefits in Britain..........................UK 9
3. Child Care Services...........................UK 16
4. Child Health Services ....UK 21
5. Family Support Services ....UK 30

   Illustrative Models...........................UK 34

CONTEXT..UK 36

1. Demography....................................UK 36
2. Expenditures..................................UK 40
3. Politics......................................UK 42

ON THE GROUND ....UK 47

1. Child Care ....UK 47
2. Child Care in Camden..........................UK 51
3. Health Care and Home Visiting.................UK 70

FAMILY SUPPORT SERVICES ....UK 93

1. A Center for Under-fives and Their Families....UK 93
2. The Child Care Center.........................UK 96

CONCLUSION...UK114

NOTES..UK116

REFERENCES UK118

INTRODUCTION

Most British social policy scholars would agree that there neither is nor has there been any explicit family policy in Britain. Moreover, they would probably agree that there has been no coherent or consistent policy in Britain regarding children or families with children and that the needs of children have only rarely been the predominant factor in decision-making. Many would insist, furthermore, that child policy in Britain has focused on poor children far more than it has on children in general, and on dependent, handicapped and troubled children even more than it has on poor children. Nonetheless, a dispassionate analysis might point out that child poverty in Britain - the proportion of children living in families with incomes below the poverty line (40 or 50 percent of median income depending on the measure chosen) was lower in the 1980s than the child poverty rates in Australia, Canada, and the U.S., if not in the Nordic countries, or the other north-western European countries.

In general, British income security policy appears to be targeted largely on aiding the poor rather than on achieving more income equality. Maintaining a work incentive for men (not women), reducing child and family poverty, and protecting children in need of protection are three social policy goals that seem to have been balanced over the last 30 - 40 years in the context of a continuing concern with limiting public expenditures.

Given this picture of British social policies toward children and their families, it should not be surprising that

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there is no special concern with children under age 3. Nor is there a government structure charges with taking a holistic view of young children. If there is any young child focus in Britain, it is with regard to children under 5, the age when compulsory education begins. But even this is very modest, and driven largely by an emerging interest in women's policy as more women with young children enter the labor market and, secondarily, by increased interest in child care as a "preventive" service for children in disadvantaged families.

THE BRITISH FAMILY - OR CHILD - BENEFIT SYSTEM TODAY

The major British social policies affecting children include both cash benefits and services. There are no special benefits targeted on the under 3s, apart from a maternity leave at the time of childbirth and a cash benefit that replaces wages lost during part of the leave. The modest "under five's" policy thrust which in some ways may be seen as a parallel to the more prevalent "under 3" policy focus elsewhere, is focused on child care services not on cash benefits.

1. The Major Family Benefits

The major family benefits in Britain include Child Benefits, Family Credit, and Statutory Maternity Benefits in addition to other social policies which in one way or another benefit children and their families:[1]

Child Benefit (CB), the current term for a child or family allowance in Britain, is a non-income-tested (universal) cash benefit provided for each child in a family, including the first.

The benefit is tax free, available until a child is age 16 (or 19 if at school), is financed out of general revenue and, since 1992, is indexed to wages. Since 1991 CB has been paid at a higher rate for the first child (£ 9.65 or $16.89 per week[2]), and at the same flat rate for all others (£ 7.80 or $13.65). CB for a two-child, two-parent family was worth about 6.5 percent of average male earnings in 1992. It compares well to the other European countries with regard to small families (those with one or two children) but poorly with regard to larger families. In two-parent families, the benefit is paid to the mother, thus becoming (at least in the UK discussion) a kind of "mothers' wage". In 1991 CB was paid to 6.8 million mothers on behalf of 12.2 million children.

One-Parent Benefit is a non-income-tested CB supplement provided for the first child in a single parent family, on the same basis as CB. The 1991 weekly benefit was £ 5.85 or $9.95. The child benefit package in 1992 provided to a single mother with two children was £ 23.30 or $40.60 weekly, making the package worth about 8 percent of average male wages (and 13.4 percent of average female wage) to such a family.

Family Credit is a cash benefit provided on an income-tested basis, that functions as a modest wage supplement to low-income families with children under age 16 (or 19 if full-time students) when the head is in full-time work (defined as at least 24 hours a week for a man and 16 for a woman heading a family alone). The benefit, which was set at £ 41.00 or $71.75 per week for an adult or couple in 1992 and £ 10.40 or $18.20 for each child under age 11 (and higher for older children) is equal to over 35 percent of average female wages for a lone mother and two children under 11 and 22 percent of average male wages for a similar family headed by a couple. With CB included, the package is worth almost half an average female wage to a lone working mother with two children, and more than one-quarter of an average male wage to a similar low-income family headed by a couple. In effect, a lone mother working half-time, would have the equivalent of a full-wage; while if she worked longer hours she would gain a significant addition to a full wage.

FC has never been claimed by significant numbers; only about half those who are eligible claim the benefit. Government officials claim that it is unlikely that more than 60 percent would claim the benefit because many families who would qualify for only a small amount will not bother claiming it. But given the easier qualifications for sole mothers and the lower wages women receive, sole mothers constitute a disproportionately large segment of those receiving it - about one third.

FC, like CB and the One-Parent Benefit are paid every four weeks to the mother in a book of orders cashable at the post office or directly into a bank account. One-parent families or those receiving FC may choose to be paid weekly.

*Employed mothers are entitled to a 40-week, job-protected maternity leave that includes 11 weeks before childbirth and 29 weeks after. Eligibility for this leave is limited to those

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* This signifies under-3 policy.

women who have worked for one employer for at least two years, full time, or five years part time. Women receive a cash benefit for only a portion of the leave (see below). There is no paternity leave, parental leave, or leave to take care of a sick child at home.**

*Statutory Maternity Pay (SMP) is a non-income-tested cash benefit provided to women who have worked at least 26 weeks before the 15th week of their pregnancy and have paid National Insurance (social insurance) contributions (or were dismissed while pregnant). The benefit lasts for up to 18 weeks of the 40 week maternity leave. The cash benefit may begin as early as the 11th week before birth, but no later than the 6th week, by which time the maternity leave must begin, if part of the benefit is not to be forfeited.

The benefit level is higher for the first six weeks (90 percent of wages) for women who worked full-time for at least two years for the same employer (or five years, part time); for the remaining 11 weeks, it is paid as a flat-rate low level benefit. Women who worked for less time, may qualify only for the lower level benefit (£ 44.50 per week in 1991), and would not qualify for the longer leave, either.

** Since the completion of this case study, U.K. adopted the EU standard of a 14 week job-protected maternity leave (two weeks before childbirth) available to almost all working women. In effect the U.K. will now have a two-tier maternity policy with a minimum leave for all working women and a longer leave for some. Wage replacement details were not yet announced.

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For those who do not qualify because they left their jobs, or are self-employed, a parallel benefit, the Maternity Allowance, is available at a slightly lower level (£ 40.60 in 1991).

Although not the focus of this analysis, family benefits in Britain can only be understood in relation to the major "safety net" program, Income Support (IS), designed to support low-income individuals and families when earnings are absent or social insurance benefits are low. IS is a means-tested cash benefit, with roots in British Poor Law, established first as a national public assistance scheme in 1948 and renamed Supplementary Benefits in 1966, and Income Support in 1986 (and implemented in 1988). It is available regardless of marital or family status to low-income individuals aged 18 or older (or 16 if pregnant or if they have a child). The IS level defines the absolute poverty threshold in Britain. In effect, similar to Supplemental Security Income (SSI) in the U.S., IS offers a national, uniform minimum income to poor individuals, one and two-parent families, and children, worth almost half an average female wage (44 percent) and 34 percent of an average male wage for a two-parent family. It is, thus, especially important for lone-parent families and about three-quarters of these families received IS in 1991. It covers the poor unemployed who have exhausted their benefits and the poor elderly.

In addition, the basic British social infrastructure includes a national health service and a system of housing subsidies for low-income families.

Finally, although not discussed here, there are child dependency additions to social insurance as there are in all six countries we are discussing. There are no longer any special tax exemptions for children. CB constitutes an integration of both tax and transfer benefits for children.

Debate continues in Britain concerning what should be the level of child benefits. Despite a recent increase in CB, its real value is now less than what it was when family allowances were first introduced. Several leading British social policy scholars as well as the leading child advocacy organization claim that families with children are now relatively worse off than at any time since the benefits were introduced.

To provide additional perspective on British child benefits, the history of the policy is summarized below.

2. The History of Family Allowances/Child Benefits in Britain

The movement for family allowances (FA) in Britain began with the establishment of the Family Endowment Society in 1918 and the campaign launched by its director Eleanor Rathbone and carried out over the next 27 years.[3] Rathbone focused on the problem of that poverty which resulted from the failure of the wage system to adapt to family needs. She campaigned actively in the 1920s, for FA to be provided by government, to compensate workers for some of the costs of rearing children. Her concept was that FA would function as a wage supplement, reduce poverty among the working poor, maintain work incentives for those on public benefits, and, finally, "would signify the recognition by the State of the value of children as future citizens and workers and of the need to make a direct economic input to the family to enable it to carry out its important role."[4]

No significant constituency emerged advocating FA during these years. Organized labor rejected the concept, viewing it as a device for maintaining low wages. Instead, labor pushed for the establishment of a minimum wage and for other types of social protection. Women's organizations were uninterested in FA as well. No political party placed the issue on any party agenda, and the Great Depression eliminated discussion of any new initiative, at least for some time.

It was World War II and its impact on concepts of government responsibility that made the difference. A 1942 government White Paper was issued proposing FA and marshalling the usual arguments in support. The government deferred action until Beveridge presented his report, apparently hoping that interest would disappear by the end of the war.

Beveridge had been an early proponent of FA, influenced by Rathbone and her writings. Initially, he viewed FA as an important instrument for reducing poverty among families with children; even more important, later, he saw FA as an effective device for overcoming the work disincentive problem which could arise if government provided unemployment benefits that would be adequate to support a family yet would not compete with existing wages.

Beveridge proposed a weekly benefit that would cover the minimum cost of a child for food, clothing, and some miscellaneous items. Under pressure from the treasury department regarding costs, Beveridge agreed to exclude first children from FA on the grounds that wages could support a couple and one child; subsequently, he also agreed to reduce his proposed benefit level because of promises by the government - never fulfilled - that additional support would be provided in kind, through school meals and free milk.

Widespread popular support for the Beveridge Report, reflecting in part, the consequences of the experience of the war years, coupled with cross-party support paved the way to legislation enacted in 1946. The first benefits were paid that year. Child Tax Allowances (CTA, reductions in taxable income for each child in a family) established many years earlier, continued as a parallel, more generous child benefit to the better off.

Even though FA were launched as a more limited benefit than planned, the assumption had been that improvement would be carried out in the near future. Instead, FA were neglected between 1946 and 1967 and their real value declined as a percentage of other social benefits and of wages. Benefit levels were raised only twice during these years, both times when child food subsidies were reduced. Child dependency additions on other benefits were raised eight times during the same period. The promised in-kind benefits never materialized. Child Tax Allowances, despite discussion, were never linked with FA; moreover, they almost doubled in value during these years while FA increased by only 60 percent.

Several analysts (Brown, 1984; MacNicol, 1980) attribute this twenty year neglect to the consequences of a period of rapidly rising real wages and low unemployment, which made FA, a very small wage supplement at best, seem unimportant as a component of family income. Added to this was the increased birth rate as Britain too experienced the baby boom, thus eliminating any possible interest on the part of those who might have had natalist concerns. Indeed, it took the rediscovery of poverty in Britain (influenced in part by the rediscovery of poverty in the U.S.) to reawaken interest in FA.

In 1965, Brian Abel-Smith and Peter Townsend published their monograph, The Poor and the Poorest. They announced that their most significant finding was the extent of poverty among children in Britain in 1960 and recommended a substantial increase in family allowance as a remedy. Soon after, the Child Poverty Action Group (CPAG), a child advocacy organization established by Abel-Smith and Townsend among others, urged a negative income tax or a child tax credit. Despite discussion and debate, the Labour Party then in power enacted no significant change. Instead, when the Conservatives entered power in 1970, some modest improvements were introduced. Family Income Supplement (FIS), the forerunner of Family Credit, was enacted, providing a modest means-tested cash benefit to supplement the income of working poor and near-poor families.[5]

Despite these modest policy improvements the value of FA continued to decline, the poverty rate remained the same, and one third of the poor were still children. For the first time in almost 30 years an organized political constituency became active supporters of FA. Women began to express strong interest and support, as did the child advocates. Continued exploration of integrating the CTA and the FA suggested it might yet be feasible. At the same time, however, the economic situation took a turn for the worse; the economic crisis had arrived in Britain.

In the 1974 election, each major political party promised support of an integrated child tax and transfer scheme. Labour won the election and immediately raised FA. Shortly thereafter, the Child Benefit Act was passed in 1975, to be implemented two years later. In fact, for various reasons it was not fully implemented until 1979. The law provided for the ending of FA, the phasing out of the CTA and the establishment of a new CB to cover all children, including the first. The benefit was set at a higher level than the FA, was tax free, payable for all children up to age 16 or 19 if a student, and payable to the mother (or other caretaker). It was still not indexed.

CB was presented as an action against child poverty and as financial support for women (by transforming the child tax relief "from the husband's pay-packet to the wife's purse", or as it because popularly labeled, "from the wallet to the purse").[6]

CB as ultimately implemented, was set at a level that was still a lower proportion of average male earnings than in 1948. For a one-child family FA and CTA combined constituted 7.8 percent of average male earnings in 1948 while CB constituted only 4.1 percent in 1982; for a three child family FA/CTA constituted 28 percent of average male earnings in 1948 and 12.2 percent in 1982.

Still another significant development occurred in the mid 1970s. Along with the changes occurring in women's roles and in gender relationships, Britain, also, had been experiencing a growth in single-parent families. The Finer Committee established by the Labour government to examine the social and economic situation of one-parent families found a serious poverty problem among them and recommended the establishment of a guaranteed maintenance allowance, higher universal child support benefits for children in these families, and an income-tested benefit for their mothers.

Although strongly supported by advocacy groups, and still cited and referred to, these recommendations were never carried out. The influential chair of the Committee died prematurely in 1974. The economic constraints of the last 15 years as well as the return to power of the Conservatives who had disassociated themselves from the report, left the program with neither political nor financial support.

In 1976 Labour did make a small gesture, by establishing a One-Parent benefit, almost accidentally. Established first as a temporary measure when first children were not covered under FA, it became politically awkward to eliminate once CB was actually phased in, since it was set at a higher level than the CB. Another move toward support for single mothers came also at the end of the 1970s, when the qualifying criteria for FIS were made easier for sole mothers.

Once again, the failure to index CB coupled with lack of interest on the part of the Conservatives left it vulnerable to a decline in real value during the 1980s. At the end of the decade proposals were made to eliminate CB and replace it once again with a CTA, to means-test it, or to target it on the under 5s. Confronted by a serious political threat, CB was saved once again by the rediscovery of high and rising rates of child poverty (Bradshaw, 1990). A new "kinder, gentler" Conservative administration came to office, and the result was an increased CB for first children (1991) and a modified FC, making it more attractive to lone mothers.

Family benefits (FB) in Britain are very modest in amount and can only have a small impact on family income. Nonetheless, they have increased income somewhat, without stigma; they have reduced income inequities due to differences in family size somewhat; they have had no known impact on the welfare of children and certainly none on the birth rate. They have been adjusted to provide a slightly more generous benefit to lone mothers but not a higher benefit to very young children, although it is generally agreed that these are the families that are least likely to benefit from two wage earners (or to adolescents, who some argue have still greater needs). Their value, as a percentage of other social benefits, pensions alone, or average wages, has not been maintained; and they have only just recently been indexed. Only when Labour and Conservatives supported developments were there significant accomplishments, and the reality is that the Conservatives never were strong supporters.

Nevertheless, FB could be described as a worthwhile instrument for raising the income of the working poor with children, albeit modestly.

3. Child Care Services

The nearest thing to a British young child policy is some emerging attention to care for the young children of working mothers (the under 5s, since compulsory education begins in Britain at that age). Even this is limited, however, by the assumption in Britain that very young children should be cared for at home, and that their mothers should be at home to provide the care; and that only children "in need" (see below) should receive subsidized free or low cost out-of-home care. Thus there continues to be widespread support for making IS available to lone mothers until their youngest child is 16 and debate about whether the government should provide subsidized child care, which is viewed as encouraging women with young children to enter the labor market.

The "language" of the child care debate in Britain focuses on the issue of "parental choice" and on assuring mothers the choice of working or remaining at home. The reality, however, is that choice is severely limited by shortages of places and the economic costs to parents of obtaining care. There is growing discussion among professionals about the importance of linking child care and education more closely; but there is little in the way of government initiatives encouraging this, primarily because of the ambivalence regarding maternal employment and young children (see "On The Ground").

Child care for the 2.3 million children under 3 in England and Wales (1992) is still divided between the education and personal social services systems. Preschool programs (nursery schools and classes, see below) are the responsibility of the Department of Education and Local Education authorities. Day nurseries (public, voluntary, proprietary) and child minders (family day care in the U.S.) are the responsibility of the Department of Health and the Local Authority Social Services departments. Some new initiatives are being established under the aegis of both departments.

Preschool is still viewed as a program of enrichment and preparing middle class children for school, from the age of 2 1/2 or 3. In contrast, child care programs (day nurseries) largely serve "children in need": disadvantaged (poor), deprived (immigrant, isolated, neglected, abused), disabled children. Moreover, this is what has been stressed in the Children Act of 1989, which mandates local authorities to provide services for children in need. Of some interest, children of working mothers are not defined as "in need".

Care by relatives remains the most common form of care used by working parents (Cohen, 1990). Domestic servants of one sort or another constitute another form of in-home care, and cover about 10 percent of the children with working mothers.

The major forms of out-of-home care include the following:

- Provision for the under 5s in primary school ("infant schools") estimated at just under 10 percent of the cohort aged

0-4, in 1989 and covering 20 percent of the 3-4 year olds. The school day is from 9:00-3:30.

- Nursery schools and classes. Nursery schools are full- or part-day preschool programs provided under education auspices for children aged 0 to 5 for forty-eight weeks per year. Part-day places (84 percent) can be provided from 9:00 in the morning until noon or from 1:00 until 3:30; full day programs operate from 9:00 AM - 3:30 PM. They offer free and voluntary education primarily for children aged 2 1/2 to 4. The nursery classes are part of the primary schools, like kindergarten and prekindergarten in U.S. terms, while the nursery schools are located in separate facilities. About 25 percent of the 3-4 year olds are in these programs. Full-time nursery class hours are from 9 AM. until 3 PM, but a few classes offer an extended day until 5 or 6 PM. Part-time places are also usually available from 9:00 until noon and from 1:00 until 3:30.

There is no charge for these places for the normal school day, but there is a charge for extended daycare when it's provided and there is a charge for the school meal.

- Playgroups are part-day, part-week programs and used by about 50 percent of the 3-4 year olds including some of those in preschool programs as well. Some 2 1/2 year olds also participate. Children attend for 2 - 3 hours in the morning or afternoon, usually for an average of five hours a week. Most are run by parent groups and only a third receive any public funding. Nonetheless, the programs are subject to national and local regulations. In recent years, because of the growth in demand for programs serving children of working parents, a number of these have expanded to providing full school-day care.

- Day Nurseries or day care centers under social welfare auspices provide full or part-day care to children aged 0 - 5. These centers include local authority day nurseries, voluntary and privately registered day nurseries. They serve about 2 percent of the under 5s, largely those aged 18 months to 3 years. They serve children with special needs primarily: deprived, disadvantaged, disabled children and those at risk of abuse or severe neglect. The programs are required to conform to national and local standards regarding health, safety, and other aspects of quality. Staff:child ratios, for example, are 1:4. The programs are free or heavily subsidized for low income parents and charge fees of about £ 150 a week for an unsubsidized place.

- Combined nursery centers offer an integrated care and education service to children from a few months of age to age 5. Many also offer informal support such as parent and toddler groups, toy libraries, drop-in centers, and so forth. They are usually open from 8:00 AM to 5:00 PM for eleven or twelve months a year. They are staffed by teachers and nursery nurses and funded and managed jointly by Local Authority Social Service agencies and Local Education Authorities.

- Registered Child Minders (family day care) cover about 5 percent of the under 5s, largely those under 3. A minder caring for a child under age 5 is limited to a maximum of three children. Typical fees are £ 50 a week.

- Temporary or Drop-in or Part-time Care Called "Adult Education Creches" These are drop-in childcare programs that are provided either for students who are attending classes or for parents in adult education or training programs. They are provided at the site for those who are in such programs and serve the under-5s.

There are also a small number of for-profit nurseries, some work-site nurseries, and a series of other types of provision for young children including:

- groups for parents, carers, and children; parent and toddler groups; 1 o'clock clubs (parent/toddler groups in parks); child minder groups; and so forth.

About 87 percent of the 3 - 5 year olds are in some form of out-of-home child care but it could be part-day and part-week. About 45 percent of the 3 - 4 year olds are in school-based programs, about 25 percent in pre-primary programs and 20 percent admitted early to primary school. Only about 37 percent of this group is in a full school day program. About 2 - 3 percent of the under 3s are in out-of-home non-relative care. There is some interest in Britain currently in encouraging employers to do more in the way of providing or financing child care for their employees' children.

The major child care issues in Britain are:

- costs and financing
- parent fees
- staff training
- curriculum.

4. Child Health Services

According to Shirley Goodwin, former head of the Health Visitors Association and a noted British child health care expert, child health services in England and Wales are delivered largely through the National Health Service (NHS) which has responsibility for general practitioner, community health, and hospital services, and the Department of Social Security, where income transfers for children and their families play a critical role in supporting child health.[7] Having already described the relevant child-conditioned income transfers, our focus here is on the child-conditioned health services.

The NHS was established by legislation enacted in 1946 and implemented in 1948. In 1974, the Local Health Authority was established leading to the reallocation of GPs, who had previously been affiliated with the Local Authority Social Services, to the new health service.

England is divided into 14 Regional Health Authorities plus Wales, the 15th region. These Regional Authorities have responsibility for allocating funds to 200 District Health Authorities, ensuring the development and delivery of health care services in accordance with national policies, and monitoring the quality of services provided. The district or local health authorities have a great deal of autonomy including control of their own budgets. As a result, there is a good deal of diversity across local health authorities in the kinds of services that can be provided. Nonetheless, there is a basic pattern which can be discerned nationally and which is consistent with regard to child health care.

NHS services are universal, available to the whole population regardless of income, and delivered for the most part free to all children below the age of 16 (or those aged 16 -19 in full time school). NHS services include: free prescriptions, dental care, vision care, eyeglasses, and prostheses as well as primary health care such as general practitioner medical care, specialist medical care, community health services and hospital services. Although the private health care sector has expanded in recent years it contributes little to child health services.

Since its inception, the NHS has improved the quantity and quality of child health services significantly. However, child health care has remained divided between community care and hospital care, and between prevention and treatment.

General Practitioners (GPs), Health Visitors (HVs), and Child Health Clinics have remained the fulcrum of the child health services throughout the past 45 years with HVs carrying primary responsibility for preventive work. Current changes may lead the GP to carry a stronger preventive role as well.

Children gain access to the primary health care system when they are born, through automatic notification of their birth to the local health visitor (HV) who is responsible for the geographic area where the family lives and subsequently connects the family with the local (community) child health (well-baby) clinic. Children gain access to primary medical care by being registered on the list of the General Practitioner (GP) covering the area. Almost all children are registered with a local GP and almost all infants are visited at home by the HV.

HVs are registered nurses with additional public health training. Many also have midwifery and obstetrical training as well. Until now and probably for the immediate future, HVs are the key individuals in health care for very young children. They provide health promotion (education) and preventive care to the population (children, handicapped, elderly) living within a geographic area or to the people registered with their primary health care team (GP, District Nurse, HV, Midwife). Young children (under 5) and their families constitute a special focus of their work.

Health Visiting began in the mid 19th century as a public health service, focused on problems of sanitation and epidemics. Its roots include nursing, sanitary engineering, and the work of lay volunteers, and involved sending visitors into the homes of families with young children with advice about health and hygiene. The first special training course for nursing and health visiting was established in 1892, a parallel to the first social work courses in the U.S. There were early ties to the cooperative movement and workers' institutes, again paralleling early settlement house work. By the beginning of the twentieth century, health visiting was provided by almost every local authority, under the jurisdiction of the local authority Medical Officer of Health (MOH) as part of maternal and child health services.

The service began as a targeted health service during these early years in that it sprang up in response to, and was mainly delivered to populations at high risk of infant and child morbidity and mortality in the northern industrial inner-city poor neighborhoods. From 1907 on, the Notification of Births legislation, first voluntary and later mandatory (1915) required the MOH to be notified of all births in his district, and on receipt of notification health visitors went to the homes. Any doctor or midwife witnessing the birth of a child was required to make such notification within forty-eight hours; if a child was born at home, the parents themselves were required to report the birth within six weeks. By World War II it was routine to visit every newborn within ten days after delivery. The NHS Act formalized what was by then already a universally available service, by requiring that it be provided in every area to all families with young children.

HVs are notified of every birth occurring within their district and visit new mothers and babies at home usually within ten days after the child's birth. They offer an ongoing service of health education (about safety in the home, for example), advice (about nutrition), parent education (about child development), information and referral (concerning social benefits and other services) and social support (by the HV or other mothers) as well as encouraging attendance at the local neighborhood child health clinic. Of particular importance, HVs provide case finding and early identification of cases of incipient child abuse or neglect, developmental lags, or postpartum depression; they offer treatment or referral as needed and as appropriate. (Social workers are required to report incidences of child abuse and multi-agency child protection committees in every area review potential or alleged cases of child abuse.) A primary focus is on establishing a partnership with parents, supporting parenting roles rather than just checking up on children's progress.

The HV's relationship with the mother is usually begun during pregnancy when the HV is contacted or referred by the GP or midwife, and thus a relationship is established even before the baby is born. They have no legal right to visit; it is strictly voluntary. But almost all parents welcome them because the service is popular, universal, and viewed as helpful.

Despite recent changes, health visiting continues to be viewed as an essential health promotion and preventive strategy. HVs make parents aware of the factors shaping their child's health that are within their control to address and ensure that all immunizations and screening procedures are carried out in a timely and appropriate manner. The combination is essential in providing good health care. Despite the fact that UK continues to lag in child health indicators such as infant mortality as compared to other north-western European countries (but not the U.S.), child health is improving in England and Wales. (The National Children's Bureau (1989) attributes the current lag to the fact that in the 1980s many families experienced a significant deterioration in their situation, including higher rates of child poverty, homelessness, and unemployment.)[8]

Although there have been no large scale evaluation studies of the impacts of health visiting, it is viewed as a very effective intervention. There is evidence that deaths by accidents within the home can be significantly reduced by health information and education strategies provided by HVs at home; and health visiting has been remarkably effective in reducing Sudden Infant Death Syndrome (SIDS)[9].

Community child health doctors (often trained pediatricians) and HVs conduct regular child health clinics giving children regular check-up, immunizations, and providing information and advice to parents about child development and child rearing. If treatment is required, they refer to the appropriate GP. If, as expected, the GPs take over more of these preventive health activities in the next few years, these community child health professionals may concentrate more of their efforts on children with special needs.

Although health visiting remains a universal service, limited resources are turning it into a more targeted one. It is not (nor has it ever been) a means-tested service, nor in any way limited to the poor, although it did begin as a service for the most deprived or those in greatest need. It is assumed to be a basic element of the UK's preventive and community health services and one to which everyone should have access. In reality, however, although the initial visits continue to be carried out to all, families at particular risk of ill health or social problems receive more attention from health visitors.

The recommended pattern for HVs is one HV to a population of 2,000 but this standard has never been implemented. The official standard is 1:4,000 and the average is 1:5,000. In fact, if a HV is working in an inner-city neighborhood with a population of 5,000 including 200-300 families with a child under 5, most of whom are poor, immigrant, and non-English speaking, the likelihood is that she will only be able to take a universal approach for the first year (five to six visits). After that, she is likely to focus only on those most clearly at risk.

About two thirds of district health authorities have a formal multidisciplinary team that evaluates and plans care for children with developmental delays and handicaps. These groups include community pediatricians, community child health doctors, senior health visitors, and psychologists. These District Health Authorities are required by law to notify the local education authorities about children with special educational needs and participate in developing an appropriate plan for meeting such children's needs.

In 1990 the most recent reorganization of the Local Authority Health Service was enacted, placing the GP at the hub of the health care system. Child health surveillance (examinations and check-ups) which previously were under the purview of HVs, are being re-assigned to GPs, who are now expected to take a more active role in promoting community child health initiatives. The HV still provides the first health care examination - and maybe even the first few - but responsibility for ongoing child health surveillance has been reassigned to the

GP, with the physician having the option of taking over the family's health supervision generally and placing the HV in a secondary position, or if the GP wishes, placing the HV on the GP's "team" and continuing to carry out basic surveillance. GPs now have a financial incentive for achieving a certain rate of immunizations among children in their practice and for carrying out the prescribed number of check-ups on children under 5 in their practice. Specialist pediatric care remains available through the NHS solely on the basis of referral by the GP.

As part of this reform, two critical issues have emerged: (1) Are as many child health check-ups/examinations needed as are currently carried out? and (2) Who should have responsibility for carrying them out? In the recent report (Health For All Children, 1990), the recommendation was that five examinations should be carried out as follows: the second day after birth, six weeks later, at 8 months of age, at 3 years, and then at 5 years when the child enters compulsory school. The current HV pattern is at least five to six visits in the first year and usually eight to ten. Even a "bare bones" package would require three to four visits during the child's first year and one to two each year until the child is 5 and begins compulsory school. At that time, the school nurse and physician take over responsibility. The assumption is that even with the change, the HV will continue to make the first universal visit, but subsequent visits may depend on the HV's assessment of risk, on recommendations from the GP, on the GP's pattern of working with the HV, or on the family's decision to sign up with the GP for these check-ups.

The NHS is almost completely publicly funded, with about 78 percent of its resources from general revenue, 16 percent from employee/employer contributions, and 4 percent from fees for services. No specific funding is provided for child health services or for any other special group. Each LHA receives funds from the government and makes its own allocations for HV services including the number of qualified nurses who are to be sent for HV training. The HV service is free to parents. The major costs of providing the service are the HV salaries and the cars that are provided for HVs to do their visiting.

Annual NHS expenditures on children are not known but were estimated on a per capita basis in the late 1980s as £ 1275 for births and £ 280 for 0 to 4 year olds (Goodwin, 1990). These figures include the amounts spent on hospital care, community health services and GP services during 1986 and 1987. Corresponding estimates for the elderly are £ 520 for 65 - 74 year olds and £ 1190 for those 75 and older. There is some concern that the most recent reforms will make care of chronically or severely ill children less attractive to both GPs and hospitals, but it remains to be seen whether this is the case.

Health visiting has been and continues to be at the heart of the British child health service. Current trends toward targeting within the basic universal framework stress health promotion more than prevention (with the latter more closely linked to the GP although still a part of the HV role). Work with mothers and parents is becoming increasingly important rather than a focus just on the child. Responding to cultural diversity is becoming more important as well in working with ethnically, racially, and religiously diverse families with very young children. Limited resources constrain the "preventive" focus although some resources have been re-assigned to the GP; one problem is that "prevention" comes very low in terms of additional resources because of the difficulty in quantifying the results of care. Health visiting is now being transformed from a "service-based" program to a "needs-based" intervention. Nonetheless, its value is recognized nationally, it is popular, it is appreciated, and it is believed to be effective. It remains a universal service for the first year after birth, but is increasingly targeted subsequently on high risk children and their families.

5. Family Support Services

Part social movement and part program development, the discussion and development of family support services in the UK has both similarities to and differences from what is occurring in the U.S. The 1989 Children Act mandates services to children in need and mandates family centers as one type of service for vulnerable and/or high risk children and their families. However, the legislation provides no specificity as to what these centers are to provide, how they should be staffed, nor even who their clients should be (other than children and their families); nor does it provide resources for establishing these programs. Thus, it is unclear how significant the development is. The mandate goes beyond children in need, the primary focus of the legislation, yet without new resources there is unlikely to be significant growth.

The Act defines family centers, the British equivalent of the U.S. family support services, as "places where a child, his parents, and anyone who has parental responsibility for or is looking after him may go for occupational, social, cultural or recreational activities or advice, guidance or counseling or the person may be accommodated whilst he is receiving advice, guidance and counselling."[10] Family centers may be operated by local authorities or contracted out for operation by voluntary agencies.

Family centers have had a very mixed history in the UK. Although some were established in the 1970s, the main developments occurred during the 1980s, against a backdrop of under-used residential facilities as British child welfare policies stressed foster family care rather than institutional care, and subsequently, community- and family-based care rather than foster family care. The centers reflect current policy preference for family-focused, community-based, comprehensive, culturally-sensitive, participatory programs, using flexible funding resources and designed to address a wide range of family problems.

A 1989 survey (Warren) identified 495 family centers nationally, ranging from public programs to voluntary agency programs, from projects under the auspices of large voluntary agencies to small, informal grass-roots organizations, from residential facilities to home-based services, from intensive professionally staffed, therapeutic programs to informal self-help groups, and from problem or deficit oriented treatment services to developmentally oriented or supportive mutual aid and self help groups. Most (84 percent) are under voluntary agency auspices.

The Children Act identified three alternative models of family centers:

1. Therapeutic, residential or community-based services for seriously disorganized families, in situations of child abuse or very severe neglect;
2. Developmental, community-based facilities offering support for normal families with very young children, or for families with modest problems, providing drop-in services, child care services, parent/toddler groups, information and advice services, counselling, adult courses and parent education.
3. Informal and formal self-help groups.

Regardless of the "model" almost all these programs characterize their mission as strengthening family functioning through the provision of supportive services designed to help and enhance parenting skills. And almost all are located in communities with high rates of social pathology, poverty, unemployment, etc. All provide some kind of child care service. All include some home-visiting and some outreach services. All are relatively informal (as compared with more traditional family service agencies). All use a broad-brush approach to intervention and rarely carry out any rigorous evaluation or impact studies. Most focus on families with very young children (under 5). Most are under social work auspices and, as mentioned earlier, under voluntary agency sponsorship auspices as well.

The population served varies too. Some centers accept only "at risk" families who are referred by other professionals. Some accept all families living in an "at risk community". Some take children (and their families) who are listed on child care service waiting lists. And some take any child or parent who wants to participate.

The types of services provided and interventions used also vary. Some have focused on intensive, family preservation type work and crisis intervention. Many are deficit-oriented programs carrying out remedial and treatment interventions with abusing parents or very disorganized families. Most offer at least drop-in child care services, information - advice - counseling services, and parent education.

Staffing patterns vary as well. Some are highly professionalized. Some use paraprofessionals, or a combination of professionals and paraprofessionals. And some use lay volunteers or "indigenous" staff - former abusive parents, parents who "graduated" earlier from a family center program.

One criticism is that more and more inadequate parents are being made to participate in parent education classes run by untrained staff, with no evidence of positive outcomes, often as a condition of getting other more practical help.

Hilary Walker (1991) points out that "the lack of research on family centers limits the information available about the numbers of different types of centers and makes it difficult to identify the direction of current developments." (p. 60) Despite the developmental rhetoric, most centers seem to be deficit-oriented, focused increasingly on problems of child abuse and severe neglect. The centers seem to have moved away from the earlier stress on broad-brush preventive work "towards the targeting and surveillance of families deemed to have failed." (p. 67) Nonetheless, they are viewed by some as reducing social isolation, giving support in crises, and providing enhanced opportunities for children to learn, play, and relate to peers. The last is of special importance in a country where most child care for the under 4s is limited to care for children in need - and children with employed mothers are not defined as "in need".

Illustrative Models

- A house with several apartments, communal living room, kitchen, dining area, able to serve a maximum of four to five severely disturbed families who have already been found to be abusing parents. Typically these are mother-only families with several children, who have been chronic problem cases in the local authority. The focus is on attempting a new type of intensive, time-limited intervention and support service that will permit return to the community with the family intact and the children remaining at home.

- A community-based program that involves child care for the under 3s and counseling services for depressed mothers, located at several sites and directed by women who themselves had been participants in earlier programs. The women are self-referred, come from the most deprived communities, and the major focus is on self-help and support. Women "befriend" other women and provide help for them. There has been a formal evaluation and the result is some positive effects. There seems to be less depression among the participating mothers and lower rates of child abuse.

- Intensive, home-based services (parent education, counseling, self-help) oriented toward less chaotic and disorganized families living at home. One apartment is available for respite care or short-term crises. The objective is to avoid removing the child at risk, from the home.

- A community-based center providing supportive services for families with the normal problems of child rearing and no immediate crises. The center provides drop-in services, child care, parent education, counseling, information-advice-referral services, adult education courses, and perhaps some training services.

- Home Start, a home-based program serving deprived families with children under age 5 (Van der Eyken, 1990). Begun in 1978 and evaluated in 1982 and again in 1988 these are family-focused, home-based services designed to "empower" parents, by helping parents to become "teachers" of their children. Like play groups and child minder groups, the program stresses self help, mutual aid, informal provision, and stems from a grass roots base. Great emphasis is placed on mothers helping other mothers. The model is characterized as developmental rather than remedial and the structure is professionals who staff the management/

administrative component of the service, who recruit, train, assign, and monitor the volunteers who in turn carry out the home visiting. Thus, the actual service within the home is provided by volunteer paraprofessional mothers.

- A child care service that is extended to include a drop-in service, parent education classes, adult education courses, self help groups, training programs, information-advice-referral services.

In some communities the hope is to develop a continuum of more and less intensive services within the community, with easy access across the services. In other communities only one of the models may be established.

As indicated above, there is no uniform or consistent pattern nationally among these family centers/family support services and no agreement as to the design of the program, the types of clients/consumers who are the recipients or users of the service, the types of interventions used, the precise goals to be achieved, or whether there is any evidence that they are achieved (and which model is more effective in reaching the goal). Needless to say, there have been no cost-benefit studies.

CONTEXT

1. Demography

U.K. is among the large European countries, with a population of 57.8 million in 1992 (OECD, 1994). Its population size is exceeded only by Germany (80.5 million in the unified Germany), Italy (57 million), and France (57 million). Among the

OECD countries, apart from Germany and Italy, only Japan (124 million) and U.S. (256 million) are larger.

Britain is an aging society, with almost 16 percent of its population aged 65 and older. At the beginning of the century, children under 5 accounted for more than 10 percent of the population. By now they constitute less than 5 percent.

The British family is clearly changing in comparison to earlier patterns. There are smaller families, lower fertility rates, more lone-parent families, fewer marriages, more divorces, more cohabitation, more out-of-wedlock births, and more working mothers.

The British fertility rate in 1992 was 1.82, relatively high in comparison to the other advanced industrialized countries. It is about the same as in the U.S., Canada, Australia, Finland, and France and was exceeded only by Iceland, Ireland, New Zealand, Norway, and Sweden among the OECD countries, with fertility rates between 1.92 - 2.2 and Turkey, with a fertility rate of 3.58. The British under-3 cohort is about 2.5 million children.

Median age of women at first marriage rose from 21.4 in 1971 to 23.3 in 1987.[11] Marriage rates have fallen while cohabitation rates have increased, with about half of all women marrying for the first time in 1987 having cohabited previously and seven out of ten remarriages preceded by cohabitation.

Marriage and childbearing are increasingly separate with the illegitimacy rate increasing dramatically in the 1980s from 12 percent in 1980 to 25 percent in 1988. Two-thirds of all extra-marital births are to women under 25 years of age. However, two-thirds of all out-of-wedlock births are registered by both parents. Nonetheless, very young children are increasingly likely to be living with cohabiting rather than legally married parents.

The average age at which women are having their first child is increasing, from 24 in 1970 to 27 in 1987.

Ethnic and racial minorities, although still a small proportion of the British population, are becoming more significant. Of the about 800,000 births annually in Britain, about 11 percent are to women who were themselves born outside of Britain and almost half of these are to ethnic/racial minorities. Although fertility rates are higher for minority groups than for UK-born mothers, fertility rates dropped for all women between 1971 and 1985, and more dramatically for minority women. Average family size among whites in Britain at the end of the 1980s was three people while among Indians and Pakistani families it was four, and still larger for some other groups.

Divorce rates are rising. About two out of every four marriages in the 1980s are likely to result in divorce and one in five children born in the 1980s is likely to experience a divorce by age 16.

Lone-parent families increased from 8 percent in 1971 to 14 percent of all families with children headed by a single parent in 1986, and 18 percent in 1991. Almost 95 percent of the increase is due to the growth in lone-mother families. In large cities, the proportion of one-parent families is even higher, for example more than 20 percent in Liverpool, Birmingham, and

Glasgow and 30 percent in London. West Indian Black families, which constitute about one quarter of British minority families with children, are most likely to be lone-mother families (42 percent). One third of the white single mothers are divorced while 40 percent of minority lone mothers were never married. A substantial proportion of divorced persons eventually remarry but remarriages are at greater risk of break-up even than first marriages.

Although not to the same extent as in the Nordic countries or East and Central Europe, British women are increasingly in the labor force. Sixty-five percent of adult, non-elderly women were in the labor force in 1990, a rate exceeded only by Canada, the Nordic countries, and the U.S. among the OECD countries. Female labor force participation rates increased by about 12 percent in the 1980s, only slightly less than in the U.S. However, 44 percent of British working women are employed part-time a rate almost double that in the U.S. and exceeded only by Norway and the Netherlands.

Labor force participation rates of married women with children have increased significantly in Britain over the past decade. More than 40 percent of women with children under age 5 were in the labor force at the end of the 1980s including 42 percent of those women with children under 3. This is a dramatic increase from the 24 percent rate in the early part of the decade. Over half of all husband/wife families with children now include two working parents, including one third of those with a child under 5.

Lone mothers with young children (under 5) were much less likely to be working than their married sisters (18 percent as compared with 31 percent) in 1986. Moreover, in dramatic contrast to their married sisters, they are much less likely to be working than previously. Their labor force participation rates have declined from 48 percent in 1979 to 39 percent in 1985. Despite these increases in the labor force participation, rates of married women with children, Gillian Pugh (1992) points out "the dominant ideology in the United Kingdom still sees women's place as in the home and taking responsibility for the care of children."[12]

2. Expenditures

Britain, like the U.S., Canada, Australia, New Zealand, follows the model that has been variously characterized as the "Anglo-American" model or the "liberal market countries" (Esping-Anderson, 1990), the "residual welfare states" (Wilensky and Lebeaux, 1958), the "minimalist" welfare states, or the countries stressing social assistance.

The countries following this pattern have developed their social policy on the foundation of the English Elizabethan Poor Law. The focus is on differentiating out categories among the poor warranting different types of treatment. The goal is to reduce poverty rather than to reduce inequality; and the primary strategy is a combination of means-tested cash benefits and supportive and behavior-changing service interventions.

Although not as low as the U.S. and Australia, Britain is consistently among the "low" social spenders generally in the

OECD countries; but given its low level of social spending it is relatively generous with regard to family benefits. Like US, Canada, Australia, and New Zealand, (and Japan) Britain is among the countries which include social assistance programs in their family benefits in the OECD data base. In effect, Britain would look still worse, and compare still more unfavorably, if social assistance was not accepted as a family benefit.

Britain is interesting both as the initiator of this social assistance strategy, but also because its history demonstrates that it is possible to do better by children and families even following this pattern. It does not result in consistent leadership but countries following this model can rank relatively high - if committed to generosity for poor children and families, and if they persist.

The limitations of the model are quickly visible, however. A narrow political base of support - and a brief time frame - are usually all that is available to those stressing an anti-poverty focus. The problem is evidenced in the volatility of British ranking over time.

Britain is unusual in that it was among the low spenders on family benefits before 1975, a leader between 1975 and 1985, and then its family benefits fell back again as a share of GDP late in the 1980s. Nonetheless, British FA for families with one child rank relatively high (fourth) within the European community, and fifth for two-child families; but Britain is not generous to larger families. In contrast, Britain has a relatively generous public assistance program that serves all low-income individuals and families, and that was basically established in its current form in the mid-1960s. Britain has a special benefit that provides a supplement to the incomes of the working poor, established in the early 1970s; and it became relatively generous during the 1970s in its treatment of single-mother families. Late in the 1970s, Britain increased its child benefit significantly, as well. All these developments show up in the OECD and EEC data; as does the precipitous drop in family benefits in Britain in the late 1980s.

Following a strategy of means-tested benefits, Britain suggests that it is possible to do better by children than other countries using this strategy have done. But British history also reveals how vulnerable such support is politically, in contrast to the far stronger and more consistent support provided in countries following a more universal strategy.

3. Politics

The British welfare state can be characterized as universal, stressing public provision, and relatively stable over time. Richard Parry (1988) describes the concept of the welfare state as essential for understanding post World War II British social policy, but no longer relevant to the contemporary scene. "Welfare programmes have entrenched themselves into public policy, supported by both political expectations and bureaucratic interests, but the ideal of the welfare state is no longer at the heart of British politics." (p. 158) Indeed, some would suggest that both major political parties in Britain, the Conservative and Labour, are now questioning, for the first time, how much of the welfare state Britain can still afford.

Parry, and earlier Ashford (1986) and Heclo (1974), view the British welfare state as resting on a fusion of two traditions: social democratic and bureaucratic rationality. It relies on public provision of services rather than public subsidy and regulation of private provision, as in Germany, for example. Its history begins at the end of the 19th century with the establishment of free and compulsory public education (1891), and with responsibility assigned to local government soon after (1902). In the early 20th century, before World War I, the Liberal Party introduced old age pensions, sickness benefits, and unemployment insurance.

The full flowering of the British welfare state, however, was left for World War II. Beveridge, the publicly recognized "father" of the British welfare state, proposed an integrated, contributory, flat-rate and universal social insurance system covering old age, retirement, disability, unemployment, sickness, and family allowances in addition to a national health service and full employment policies. Although the full proposal was not implemented, a significant part was, and left its mark on present British social policy.

Much of contemporary British social policy continues to resemble the pattern laid out in the 1940s. Between the mid 1960s and mid 1970s another effort was made to expand the British social protection system, but only modest changes were carried out: a reorganization of the local authority social services (the personal social services) in 1970; the introduction of an income supplement for low-income working families (FIS) in 1971; a reorganization of the National Health Service in 1974; the transformation of the flat-rate pension into an earnings-related pension in 1974; the integration of the family allowance and the child tax benefit into a Child Benefit in 1977, implemented in 1979. The 1980s brought stagnation, once again, with a Conservative government in power. Nonetheless, except for housing policy, the basic social policy pattern remains the same. There is continuity of organization, financing, and the major regimes. There has been no significant expansion of beneficiary groups (except for the first child now covered by Child Benefit). There have been some efforts at privatizing the personal social services delivery system. But overall, continuity has been the theme, not change.

Of all British social policies, family (child) benefits have varied the most in British income transfer policies. As Bradshaw (1990) points out, the situation of the aged improved significantly in Britain, but the situation of children, in particular in the 1980s, deteriorated substantially. The real value of family benefits declined. The increase in lone-mother families led to more children living in economically insecure situations. The growth in the numbers of long term unemployed dependent on low-level assistance benefits increased. Family benefits did not begin to compensate for this, nor, of course, did assistance benefits.

FA as legislated in 1946, were designed to eliminate possible work disincentives in existing social benefits as much as they were aimed at reducing child poverty. Benefit levels, however, were lower than originally recommended and far lower than was thought necessary to provide subsistence level child support. Thus, the actual value of FA/CB was not generous to begin with and never as great later as it was in the early years. Benefits peaked in value and as a percentage of male earnings in 1952.

FIS was introduced by a conservative government as a means-tested wage supplement for families with children, and as a cheaper device for alleviating child poverty than universal FA. It has never been claimed by all who should be eligible. It is still stigmatized but take-up by single mothers is relatively high and recent reforms have led to higher take-up.

The 1977 CB reform was explicitly designed to reduce the poverty problems of low-wage working families with children and to help equalize the financial burdens of families with and without children as well as to maintain work incentives. A significant improvement over FA at the time, CB never fully matched the original FBs available at the end of the 1940s. The recent improvements have helped despite the fact that the proposal to target CB increases on the very young (under 5s) were rejected in favor of an increase for the first child. In the long term indexing will surely help still more. But the present value of CB is still lower than the original value.

In effect, there have been only two significant periods in the development of social policies for children and their families in Britain:

(1) The 1940s when FA were first legislated and when widespread popular support, government and cross-party support was strongest.

(2) The late 1960s through the mid 1970s, when a second wave of interest in child poverty emerged. A Conservative government limited action to a means-tested wage supplement in 1971. Labour's return to government in 1974 and continued public concern about child poverty culminated in the integration of CTA and FA; more generous support was constrained by resource limitations. A move to do more for children in single-parent families was never implemented.

FB never had the financial, popular, political support given pensions or the NHS. Child health care has been protected as part of the popular and protected NHS; and child care would probably have received more support if Labour, with its newfound interest in women's issues, had been elected in 1991 instead of the Conservatives. But FBs have never had strong political support and a more comprehensive child and family policy certainly has not either.

Azevado (1992), an Italian economist writing about European family policies and welfare state developments, points out that "There is no population policy in the United Kingdom, neither is there a family policy in a political sense."[13] Family size and birth rates are considered private matters, not issues for public policy. Population levels are not considered indicators of national power as they are in some countries. There is no effort at coherence among social policies affecting families with children. Moreover, there are no traditional family organizations that act as a pressure group supporting child-related social policies. (Indeed, in contrast, there are effective nontraditional family advocacy groups such as the National Association of Single Parents; and there are effective advocacy groups focused on poor children, such as the Child Poverty Action Group [CPAG].)

Political parties, Azevado argues, do not have specific family policies as part of their platform. "The different interests, values and ideologies surrounding the family in the United Kingdom, and the pluralism in family form and functioning contribute very much to discouraging politicians and policy makers from formulating an explicit family policy. More comfort is found in generalized assurances of support for the family and family life rather than in the articulation of specifics." (p. 4)

ON THE GROUND

1. Child Care Services: Overview

The British childcare system is fragmented as to auspice and program, diversified regarding philosophy, curriculum, and program focus, very inadequate as to supply, and of mixed quality at best. This has been the general picture for a very long time, but the problems are now exacerbated by a recent administrative shift in auspice for child care in some locations from personal social services to education, recent funding cuts by the central government to the local authorities, and funding problems of the local authorities in attempting to compensate for these.

To understand the British system one has to recognize first, that compulsory school begins at age 5. Second, almost all the 4 year-olds are already in some type of a group program, either part- or full-day, most in what are called reception classes (like kindergarten in the U.S., for the 5 year olds). Nursery school education is also quite extensive for the 3 year olds, but these are overwhelmingly in part-day programs. In contrast, those children who are "at risk" and have some kind of problem or whose mothers are working may be in day nurseries; but this is very limited provision in relation to the larger numbers who are in the education programs. Few under 3s are in out-of-home care, and when they are, the care is most likely to be family day care.

To provide some illustration of the complicated and fragmented nature of the British childcare delivery system we briefly described earlier the various program types: Nursery schools; nursery classes; day nurseries; playgroups; child minders; "crèches"; and, in some locations, "Under-Fives Education Centers". Here, we provide more detail on the most interesting developments, stressing as well the enormous diversity from program to program even within the same category.

All the types of child care/preschool are now available under education authorities in Islington (London) and there are similar types of programs in Camden Borough. In contrast there are still other boroughs and other parts of England in which childcare is still provided under social service auspices in day nurseries. In such communities there is also, however, parallel provision of nursery schools and nursery classes under educational authorities.

In London and some other parts of the country, childcare is in transition from personal social services auspices to education and from a custodial service to an "integrated" care and education service. In reality, what is occurring is co-location of two philosophies and two professions now under one auspice (education) but without real integration. Moreover, despite the growth of female labor participation rates in recent years, the programs are still designed largely to serve children at risk, not the normal children of average working parents. Nor has the administrative integration with education eliminated the stigma attached to childcare since the Children's Act mandates priority for children in need and therefore the education authorities who are administering these programs follow the same priorities, leaving the programs dominated by children in need, at risk, with problems. Although some local child care officials insist that these are developmental programs and not deficit model programs, nonetheless directors are required by law to give priority in enrollment to children at risk and 70 percent of all children admitted to the programs must be in this category. The programs are certainly not seen as essential socialization and developmental experiences for all children aged 2 to 3 or 5 as they are on the continent. Finally, almost all of the current expansion is for 3 and 4 year-olds with very little for the under-3s.

From our perspective, even those programs that are viewed as exemplars do not compare well with programs in northern Italy or with the Scandinavian childcare programs, nor with an average École Maternelle in Paris.

Since the transition to the educational auspice ten "Under-Fives Education Centers (UFECs)" under education auspices have been established in one London borough. The UFECs are run by the council government (the local government) and provide care and education for children under the age of 5 with most places for children aged 3 and 4. Parents are said to be encouraged to be part of the center and to be part of the center's management group. Fees are on a sliding scale according to income except for the core "educational" part of the day, which is free. (See below). It is also free for children in families receiving Income Support and Family Credit. All include both full- and part-day programs organized around the concept of a core day which parallels the school day from 9:00 to 3:30, and an extended day, which begins at 8:00 in the morning and ends somewhere around 5:00 or 6:00 in the late afternoon. Each center has a "Head" who is trained as a teacher, two deputies who are either trained as teachers or in childcare, and five staff who may or may not have childcare qualifications. Among the staff there is always at least one staff member with responsibility for the under-3s and one who has responsibility for children with special needs. It should be noted here that these are centers that may have been day nurseries or nursery schools before but have modified their philosophy in some way and/or had their hours extended. By April, 1992 all the Heads were in place, and by the fall of that year, all the teachers. We were told that there continues to be intense administrative tensions, bad morale and so forth because the teachers on the staff of these programs work a normal school day and a normal school year and get paid more than the childcare staff, who work a full day and all year.

2. Child Care in Camden

Camden, London is a racially, ethnically, and socio-economically mixed community with a high proportion of working parents and relatively "good" (for Britain) child care coverage. About 25 - 30 percent of the population are minority. Child care services include the usual mix (children's centers, nursery groups, nursery schools and classes, day nurseries, and child minders in family day care homes). Playgroups - part day and part week - are increasingly obsolete here as in a number of other communities in Britain, as more and more mothers of young children remain in or enter the workforce and need more regular, full day care. Increasingly, playgroups are extending their schedules and are being brought into the larger child care system. There are very few employer-sponsored programs. Since April, 1992, the education department has full responsibility for all child care in Camden, including all the types listed above.

About 39 percent of the 0-4 year olds, overwhelmingly the 3-4 year olds (71 percent), are in full- or part-day child care in one of the group programs. Of these, 70 percent come from the

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high priority list, children referred by social workers (CPS cases), health visitors, district health authorities. Almost all centers have at least 1 - 3 disabled or special needs children enrolled. The remaining 30 percent come from the "standard" waiting list, overwhelmingly the children of two or sole working parents, with the latter having a higher priority than the former. Both waiting lists are long but the standard waiting list is about seven times as long as the priority list. Twenty percent of the 2-3 year olds in the borough are in the programs and less than 9 percent of the under 2s. Camden had been unusual in having some protected spaces for the under 2s, but this changed as the result of a tragic death in the early 1980s leading several local authorities including Camden, to stop serving the under 2s, even in family day care.

Of the children served, about half (53 percent) were British/European, 33 percent Black (Caribbean or African), 9 percent Indian/Bangladesh/ Pakistani/Sri Lanka, and 6 percent south-east Asian and Chinese.

Staff are overwhelmingly female (94 percent) and more than one third are minority. Most centers have student placements; many use volunteers in addition to paid staff. Almost 60 percent of the staff are defined as "qualified" meaning they have the appropriate level of education.

In addition to these centers, the primary providers for under 3s in care, in Camden as elsewhere in England are family day care providers. Generally, they are one of three types: (1) women who have been caregivers for many years who are likely to reject new ideas and training opportunities and rely instead on established patterns and experience; (2) new mothers who had difficulty finding child care for themselves and decided to stay home for a while and care for their own child and one or two others, and are very open to training opportunities; and (3) former child care staff who view themselves as expert and are not interested in any new training. In general, there is a high turnover rate among these providers, far higher than the rate for center and nursery school/class/ staff.

Both public programs and voluntary agency sponsored programs co-exist in the district. They all are subject to the same standards although voluntary programs appear to be able to be more selective about the children they admit. The costs for these programs in 1992, including both capital and operating costs, ranged from £ 139 - 175 a week per child in care, for 3 - 4 year olds; family day care costs are significantly lower, ranging from £ 50 - 80 per child for a 40 hour week in care.

One public (local authority) children's center visited is located next to a child health center in a low-income community in Camden. Thirty-five children were enrolled, and the facility was expanding to fifty-two the following fall. Two thirds of the children are from the high priority waiting list. The age range is 18 months to 5 years, including one group of six children under 2, ten aged 2 - 3, and two groups of 3 - 4 year olds (the second beginning shortly) with eighteen children each. One of the groups is described as a "social services group" with its own special curriculum and the second a "nursery school group" with its curriculum. In effect, the integration of child care and education here will be the co-location of two classes with very different philosophies and staff.

The center is open fifty weeks a year, from 8:00 am to 6:00 PM, but most children are there from 9:30 to 3:30. For the thirty-five children now enrolled, there are nine FTE staff (eleven individuals), most qualified (NNEB) and the remainder highly experienced.

Most of the children participate for two years, and then enter primary school; a few may leave earlier if offered places in nursery classes or schools. Once a month the priority list is reviewed and if there is an opening, a child is picked from that list and the parent(s) notified. Staff have very little influence over which children are selected, whether they will contribute to the functioning of the group, etc. In the fall, when they expand, they will change from the sibling-type grouping that they now have (mixed ages in each group) to an age specific grouping.

About half the children are minorities. Great stress is placed on responding to ethnic, racial, and cultural diversity. There are special festivals, meetings to emphasize diverse content, signs in several languages, books about children from different countries, exhibits that show discussion of things in different countries, and active involvement of parents from different backgrounds.

The facility was enormously cluttered, with games, hangings, displays, signs for the parents, signs for the staff, bulletin boards, etc. Nowhere was there open space, or even sufficient space to move around easily. The outside door is kept locked and mothers must use the buzzer and intercom at the entrance to be allowed in to the small entry hall. Another locked door admits one to a corridor. On one side is the director's office and a staff room. The children's rooms are lined up off both sides of the corridor, a heavily trafficked and also cluttered hallway, with shelves for books and toys and a doorway to the adult bathroom, with signs indicating this in six languages.

Each group room is laid out like a small apartment, including a "large" (relatively) "activity" room, a section near the entry for hanging clothing, a small resting and quiet play room, and a toilet and changing room. The three groups are all kept closely contained, each in its own set of rooms with no expectation that children might wander into another room; and the doors are kept closed. The only time children wandered a bit was in the outdoor space which could be accessed from the activity room of each group. A group of 2 - 4 year olds were playing outside in a not very attractive outdoor area of concrete and sparse grass. Each group of the 2 - 4s spends a half hour outside each morning and afternoon. There was no shortage of supplies and equipment, but what was there was not fresh or well kept.

The children who arrive before 9:00 are offered breakfast in one room; otherwise there is a snack at 10:00. There is free play until about 10:00 am, lunch at noon followed by a rest and an afternoon snack at 3:00. The children who stay late get tea at 4:15. Children may have drinks whenever they wish.

The curriculum was explained as having components of science, social awareness, creative play, physical play, language, mathematics, etc - but it seemed very abstract and not well integrated into the experience of the children. Children were appropriately active and interactive and seemed satisfied but the environment was not exciting. There was one large room that could be used for active physical play at different times, by each of the groups. It is also used by child minders from the neighborhood as a drop-in center. The under 2s had their own room and adjacent changing room. Meals are delivered from a nearby school but an on-site kitchen provides breakfast and snacks.

One could find many similar places in the U.S. This could be a U.S. daycare center in an underprivileged area, with relatively unsophisticated but dedicated staff who try to do well by children and are making use of inadequate space and doing their best with limited training and experience. They are not harming children but they are certainly not optimizing the opportunity.

A second child care center is a community nursery, a former demonstration child care program, located on the grounds of a university and adjacent to a nursery school serving 3 - 5 year olds in two part-day programs, morning and afternoon. The child care program is open 11 months a year and serves forty-two children aged 2 - 4, largely 3 and 4 year olds, with a staff of twelve, from 8:30 - 5:30 but largely 9:00 - 3:30, the core day. It is subsidized by the local authority (40 percent), a local foundation (40 percent), and parent fees (20 percent).

The children are divided into three groups: (1) a group of six "babies" (1 - 2 year olds) and two staff; (2) a group of twenty 2 - 4 year olds; and (3) a group of sixteen 2 - 4 year olds. Each of the two groups of 2 - 4 year olds are subdivided into two smaller groups for at least part of each day. About a third of the children are black, and cultural sensitivity and diversity is a major theme (part of the ideology of childcare throughout this area).

Staff:child ratios are excellent: 1:5 for the 2 - 4 year olds (in contrast to 1:13 in the adjacent preschool program) and 1:3 for the under 2s. Operating costs are about £ 120 a week while parent fees are 40: for the extended day and £ 25 for the core day, lower than in the public program described above.

The physical plan involves entry along a long ramp in a park-like area with some of the grounds set off artificially with benches and flower pots, etc. to avoid nearby construction work. The building opens into a relatively long hall and lined up sequentially to the left are the Director's office, a staff room, and the kitchen. Outside the Director's office are little envelopes attached to a bulletin board which contain the weekly fee billings for parents and other little notes and reminders and in which they can present necessary information. On the right is one children's group room and then beyond, on both sides of the hall, are the remaining children's rooms, labelled according to colors: yellow, blue, red.

In addition to the child care staff, there is a cook working five hours a day, a housekeeper working four hours a day at cleaning, laundry, and help with the cooking. All meals and snacks are prepared on site. There is one male on the staff and there is another man doing some chores who seemed to be actively involved with the children. The one male present is black and he was working with a group of four children with clay.

The facilities for each group include a larger room and a smaller room for resting and quiet play. Each group also has a small entry room, with pegs for clothing, which will be full of heavier clothing in the winter, photos of the children, and bags of their special possessions such as changes of clothing or a teddy bear. Here, in contrast to some other places, the toilet room has three toilets for each group and three wash basins. And here for the first time we saw a toilet arrangement in which there actually are cubicles which can be closed by the children for privacy. The groups have similarly organized space, but each group team plans its own activities on a weekly basis. They also schedule together how they will use the shared space, such as the outdoors and the large activity room.

The staff arrive at 8 o'clock and set up equipment for the activities in the group rooms and also outdoors, allowing different possibilities for different days, e.g., one day there will be bikes outside and another day there may not be. One day there will be construction equipment or painting equipment in a room. When children arrive early with parents they go into one large group room where they have breakfast and then go their own group room where they have free play activity until 10:30. At that time staff take more initiative regarding an activity. At 11:00 the children go outside to play and at 11:30 they begin to come in for lunch, which is served at noon. At lunch each staff member sits at a table with five children and there are four tables in a room, each staff member sitting with his or her "key children".

In this program there is an emphasis on the concept of a "key" staff member for each child, having lunch with that child, greeting that child in the morning, and (see below) even participating very actively in the induction of the child to the center through a home visit. This is a very popular concept in British programs.

In all rooms and at all times we found considerable child-child interaction and discussion and in most of them an adult sitting with one or two children in quiet activity in which that child was involved. This was quite comparable to some of the better places we have seen, with creative adult- child interaction, a calm environment, very good talking together by children, pairing off to play together. Given the time of our arrival, there were children sleeping in the quiet rooms for each of the groups. The children had their own mattresses on the floor, they were covered with blankets, and they were sleeping soundly for quite a long time.

The blue room up to now was used as a shared breakfast room, and has recently been renovated. The next week it will become the room in which a new group of six babies and two staff will be added. They had to pick the six off a waiting list of about twenty babies. The children who come for breakfast will now have breakfast in their own rooms. Each of the group rooms and the main room have a large window wall which opens to the outdoors. Here too the rooms have designated curriculum areas, one is for language and books/ another for craft and construction/ another for waterplay for painting, etc. To an outsider, these areas are very close together. They simply really are places where supplies are kept, but to the staff they represent places where activity may begin and spread out. The staff are very serious about these curriculum areas and curriculum planning and they tend to have activities that extend for a week or for a number of days' time. In a sense it is the pattern or the themes that we have seen in other childcare centers. They also create activity areas. For example, they have several trolleys (carts), one with books. When they want to create an activity area they wheel the trolley to the proper place. In one room we found a group of children sitting in the area where the room joins with the outside at a large table and setting the table, carrying out a "tea service". In the same room a man was sitting with a small child in intense discussion. Elsewhere we saw a teacher showing children various water combinations and pouring water in and out of different kinds of receptacles. When we asked about the indoors and outdoors in this particular room we were told that they were settling down for quiet play after lunch because some children nap and all rest then. The children come together with a staff member, are read a story or have a discussion. Some then go off to sleep.

Three days a week they may split age groups off and conduct activities which are age specific, such as something specifically for the 3s or the under-2s. The staff might develop an idea for the week and then the 3s and 4s would have an all-week project. When they do this they reserve one of the sub-rooms that are assigned to the group for this or they go to a special place if that is more more appropriate. One problem is that they only have three full "sets" of rooms and the one for the babies. Thus there is no place to split off into still smaller groups, no place to meet new parents, etc., and when winter comes and they cannot use the outdoors, things are even more confined.

The outside area was fenced-in and situated next to a much larger area serving the nursery school next door, but all located in a park-like setting. The outside is set up each day by one of the staff members who comes in at 8 o'clock in the morning (the children do not arrive before 8:30). At the end of the day the children help put away whatever equipment has been put outside. There isn't a sense of a lot of clutter but rather a select group of toys and equipment plannfully placed around. There was climbing equipment, a slide, and large automobile tires out on the ground the day that we were there. On other days there may be bikes, cars, water play. They're trying to get the area landscaped so it will be even more conducive to the children

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playing. As part of "selling" this to parents in the local committee they had the children tell what they needed outdoor space for but didn't have and then drew pictures of what they thought the center needed.

In general, this was far more attractive than the previous center. Despite real constraints, space is handled very well, there is a very nice environment for children and active interaction between children and adults. Nonetheless, from our perspective this center had one major inadequacy and that is the lack of a large central area where all the children can play and where there can be interchange among the groups and across the rooms. In effect we have perhaps been captured by the Italian programs' concept of the "*piazza*", and we saw a similar pattern in Denmark in the newer facilities and are convinced that this adds enormously to the child-to-child and staff-to-child interaction. The director explained that the architect had already made his plans for this temporary building before she was hired. Each group was given a rather large room. It was she and the staff who convinced them to use folding walls in order to break each room in two and have one larger room and a second smaller room so there could be a quiet room as needed; but they had no more leverage in relation to the basic plan. In fact, the original concept when the facility was first designed was that there would be two rooms for the children, each one serving twenty-five children. It was quite clear when she assessed the footage that this would not meet standards.

They have a general staff meeting once a week from 8:30 to 9:30 and at that time they ask those parents who are not working not to bring their children until after 9:30. In that way one staff member from each group is able to cover the group while the others are in the meeting. There is also a business meeting once a month that involves one staff member from each group, representatives, and parents as well. There is a management committee for the nursery that meets once a month. Here there are staff representatives, parent representatives, representatives from the nursery school next door, representatives of former parents, representatives of health visitors. There are also representatives of the community at large. The management committee has the primary responsibility for recruiting and hiring the director, while she in turn recruits and hires other staff. However, there is an interviewing committee for hiring the other staff that includes representatives of the management committee as well as of the staff.

We asked about the difference between this program and the nursery program next door. They explained that staff in this program were "nursery officers" while those in the other program were "teachers". The other program operates on a "session" basis, including one session from 9:00 to 12:00, a second from 1:00 to 3:30, and some children who remain for both sessions. The other program has an "educational focus" while this one includes a strong "nurturing" component as well. Most of the children who attend the other program attend on a part-day basis and all of them are at least 3 years of age. In other words, the other group is 3 and 4 year olds only. In contrast, this program has a "care and education" focus, serves children even below the age of 2, and covers the normal working day as well. Finally, there is a difference with regard to staff/child ratios and group size. This program has a staff/child ratio of 1:5 for children aged 2 to 5 and 1:3 for children under the age of 2. In contrast the program next door, which serves children from 3 to 5 years old, has a staff/child ratio of 1:13.

There was much discussion about whether the curriculum in the two facilities is the same or not. The director of this program suggested that there was a distinction between the two programs but the administrative person who represented the Camden Borough Department of Education thought that the curricula were very similar and that the only difference might have been the longer day and the nursery program, the higher staff/child ratios, and perhaps a little more "holding and carrying". Thus they explained also that they were responsible for a good deal of the toilet training for the children who would be there for much of the day, and for teaching a child how to eat as part of a group, and other socializing activities.

The fees for the program are £ 25 a week for a core day, that is 9:00 to 3:30. For an extended day, from 8:00 in the morning until 5:30 in the afternoon, the fee is £ 40 a week. The actual costs were defined (somewhat arbitrarily and subject to change after the first year of operation) as £ 120 per week. That is the full operating cost divided by forty-two children, but without any subsidy. It ignores all capital expenses as well. The director now thinks that that is probably an underestimate of actual costs.

The director talked about the advantages and disadvantages of operating a voluntary agency sponsored non-profit childcare program. The disadvantages seemed to have to do with the problem of coping with physical things that go wrong, such as a stuffed toilet, a stuffed drain, something wrong with the stove, and so forth. Where a public program would just call up the department responsible for repairs and get somebody to fix it, in a private program the issue of costs has to constantly be kept in mind and therefore every effort is made to handle repairs by themselves or to look for some help from parents or to look for the cheapest possible provider.

On the other hand, it was agreed that the big advantage in such a program was that they can choose the children they want, have the kind of mix that they want, and ensure that they have a critical mass of average, well-functioning children, not a large group of children with problems. As a result, this nursery is viewed as a very attractive place. When openings are available the middle class professional parents in the community are likely to immediately respond with enormous enthusiasm and delight at being able to get in. There is certainly no stigma attached to this while there is a great deal of stigma attached to most of the public programs.

This discussion generated a comment about how some parents anxious to get their child accepted into a subsidized childcare place would lie and claim that they were going to abuse their children if they couldn't get such a place for their child. The director felt that this had potential negative consequences that went beyond the superficial because parents might be labeled in this way and it could be difficult for them later on.

They do not permit children to be placed on the waiting list before they are born, but there is a long list of waiting people, nonetheless. One can list a child if one is home on maternity leave. There is some priority for the siblings of children in the program. As soon as a place is available they convene the admissions committee and select an appropriate child, one who needs the program and one who will be a good fit in the group. As already indicated they pay attention to the balance of the group, how the child will fit in, contribute to the group, etc. As soon as they know that they are able to admit a child, they write a letter and ask for a response. The parents answer very, very quickly. Then they schedule a home visit to the family by the director, the deputy director, and the person who will be the key worker. They take a partially filled out application form and complete it during the home visit. There is a page with facts about the child, a page with cultural information and health information, and information about the parents. While at the home, as the director and deputy are filling out the other parts of the application in interaction with the parent, the key worker is on the floor with the child, with a bag of toys she has brought, revealing some of them, getting a response from the child, and testing the child's interest. This is the beginning of the development of a very important relationship for the child and they want it started immediately. The eventually completed form tells an enormous amount about the child, his or her patterns and needs, medical problems, special situations, patterns of activity and adaptation. As part of the interview they explain the fee policy. They then plan a two-week settling-in period with the parent. The details are carefully thought though, but can be stretched out or condensed as needed. If they have several children coming in at once, they actually phase in the settling-in period with two weeks between children; this allows a two-week settling-in period for each. This is essential because the key worker is heavily involved with the child during that period. In a sense, all of this is representative of the high level of professional involvement, the considerable sensitivity to children and their parents.

After a child has been in the setting for a period of six to eight weeks the parents meet with the key worker for a "settling-in" report and the beginning of a child's book. The book is a loose-leaf with a picture of the child and the child's name on the cover, in a bright cover, and at each conference they collect work samples, make a record of what the child is doing, having talked about the child and covered all the curriculum areas. This is done every six months and the material is added to the book. Finally, at the end, there is an evaluation signed by each. At the end of the child's relationship with the center, usually after two years when they enter primary school, the family takes the book home. When we asked what they are looking for in these meetings, the director spoke of child well-being, of emotional and social development, how the child plays and shares, the level of self-confidence, how the child relates to peers and adults, physical development, language development, literary development. In short, these are all the categories which appear in the curriculum guidelines from the Camden education authorities. When we asked how the parents felt about having reports about all of this, whether it did not seem to be evaluative, the director stressed that they do all of this in ways that avoid the judgmental. They make it unnecessary for the parents to appear defensive, but use it as a device for clarifying what they are trying to do and where the child is.

There is a lot of parent involvement. To illustrate, last week a parent spent three days cleaning out the outside area and fixing things up. Another drives a mini-bus to take them on outings. One takes on the Chinese translation for the Chinese parents.

When asked to characterize the program, the director said that they offer a flexible service to meet the needs of working parents as well as the needs of a diversity of children. Thus, for example, this is a program which makes it possible for children to be left early in the day, to stay later in the day, to be there only part of the day, to get individualized staff support in response to their particular kinds of needs. As a staff member said, "We provide a kind of flexible friend to working parents."

Nonetheless, she acknowledged that since they have to charge fees in order to survive, and that 20 percent of their costs depend on parent fees, they must exclude most poor families from the program. In this community with a very large Bangladesh population of recently arrived immigrants it means that almost all of these families have to be excluded. At the present time, out of forty-two children and somewhere between thirty and forty families, thirteen families pay nothing or less than £ 5 per week because their fees are subsidized either because they are receiving Income Support or unemployment benefits, or they have very low income. Actually this is more than the program can afford if it is to sustain its current fee schedule. They can really only afford to subsidize seven to ten children, but because they have a commitment to siblings and have certain expectations of what they should provide, they will probably compromise and support eleven children. This would mean that 25 percent of their children are on no or low fees and heavily subsidized. Even beyond that, of course, is the fact that given the fee schedule of £ 25 per week or £ 40 for the extended day and the estimated costs of £ 120, all children are extensively subsidized, it is just a matter of how much.

This director was clearly a professional, well informed about child development and sophisticated about programming. Both the directors of the two centers just described and the staff compared well with one another, although the second program seemed higher quality than the first. Despite this, however, even this program didn't compare well with programs that we had seen in Denmark or Italy or even some in France. And, here too the focus was on 3 - 4 year olds, with very few under 3s enrolled.

3. Health Care and Home Visiting

A young health visitor (HV), with just one year of experience works in a local London borough with large housing projects, single-family homes, and high rise apartments. She does not drive, but this presents no problem; the families she visits all live within walking distance. Today's visit is to an apartment in a low-rise building near a small park with a playground. The visit was to the home of an American woman in her late 20s and her British working class husband. The apartment was modest: two bedrooms, a bathroom, a living room, kitchen and dining area. The visit took place in the living room, where there were two couches, a table with a miscellany of books and toys, a rug on which the baby was playing with several stuffed animals, an electric "fireplace" and shelves with books, toys, and a miscellany of objects.

The visit was planned for this day because it was the baby's first birthday. The baby had been born with a congenital heart defect and the HV had visited more frequently than usual. Moreover, the American mother was quite isolated with no family nearby and no British friends.

The particular reason for this visit was that the pediatric dentist at the clinic had noted the child's heart disease and felt that the parents should be warned about the dangers of bacterial infection and the need for special procedures when the child was seen by a dentist. It had been decided that the HV would discuss the potential problem with the parents, give them some literature, offer them a consultation with the pediatric dentist and arrange for such a visit.

The last visit had been a month ago. The mother, who came to the door to admit us, was in jeans and a T-shirt. Her husband, similarly dressed, was holding the baby. He had waited for the HV visit before leaving for work. The mother had just returned from the U.S. where she had visited her family. While there, the baby had begun to stand and to drink from a glass. It had been a successful visit but the woman was glad to be back with her husband.

The HV did not examine the baby; she told the parents about the dentist, provided some material, offered the appointment and the parents immediately accepted and scheduled it. The father left then and the baby cried a bit before being distracted by its mother by being held and read to.

The mother asked the HV questions about the baby's food. The mother wanted advice about introducing new foods. The nurse responded and then discussed the next set of inoculations the baby would need. The nurse also asked about the baby's last visit to the heart specialist before going to the U.S. and the mother talked about how wonderful the special hospital and physicians were. The nurse continued to reassure the mother about how well the baby was doing. The mother talked of wanting to prepare for a teaching career while the baby was young, and the nurse told her about extension courses that could be done part-time. They discussed child care as well and how to go about seeking a responsible sitter. Her mother-in-law comes and baby-sits sometimes but once the baby walks, she may be too active for her.

The HV asked if she had other questions and the mother pulled out a list she had made: questions about giving up the bottle, about new foods, about weaning the baby (which the nurse encouraged), and about the child's constipation. The child was getting a stool softener to minimize exertion, given her heart problem. The HV suggested the mother discuss this with the doctor on her next visit.

At this point, the HV jotted some notes in the health record that is left with the parent, made an appointment to visit the next month, told her that she would schedule an appointment with the dentist and call the mother to confirm the date. Then she left, satisfied that she had accomplished what she had intended.

A second visit was with a very experienced HV who had worked for almost ten years in this part of the county. The mother we visited had just given birth ten days ago to her third child, a little boy. She had a girl of 8, a boy of 3 and 1/2, and now an infant. The HV had met the mother before, while she was pregnant, but this was the first post-birth visit.

The family lived in a low-rise housing project across the street from the health center. It had a rather barren look, with no adults walking on the sidewalks or children playing. The entry to the building had peeling paint, empty cans and beer bottles and a sense of disrepair. There was a buzzer at the door installed initially for security purposes but no longer working. The HV commented that the elevators tended to be filthy and smelled of urine and so we walked up the three flights of concrete, dirty, trash-strewn stairs. On the second floor we met a 3 year old girl who was watching for us. She introduced herself as "Kelly" and asked if we were "going to Harry's house". She announced she would show us the way.

She accompanied us to the apartment and was given permission by Harry's mother to come in, too. Harry, the 3 1/2 year old, had stayed home that day to meet the HV. The apartment was modest, but had three bedrooms. The mother told us she had just moved in before giving birth, qualifying for it because of the third child. The living room was cluttered and shabby but comfortable. The TV was on and remained on while we were there. Harry was wearing a Batman costume and played with his friend, and sometimes with the baby.

The baby was the one spotless, shining object in this home. Clearly well cared for, he was dressed in a clean coverall that was about two sizes too big for him, so that the sleeves hung below his hands. Since he periodically began to root it might have been frustrating for him, because he could not really get to his thumb. Nonetheless, for the hour that we were there he was content, responding to his mother's voice and his brother's voice, to light, and not fussing at all. He was in a baby seat, periodically touched and talked to by his mother, patted and poked by his brother. The atmosphere was easy and relaxed. The mother talked about what a good baby he was and how she guessed if you were going to have three children, the third had better be good or he would never survive. She had humor and seemed relaxed and easy in her role.

The HV used this visit to obtain standard information. She focussed first on the mother and on her experience in childbirth. Thus she asked how long the labor was, which hospital she had gone to, who the doctor was, who the midwife was, how did the midwife come, and so forth. The baby was born on June 23 (and this was July 2). She had been in labor for only four hours right after her waters broke. It was her husband who had really been fussing, she said, since he wasn't sure what to do, but she herself had been quite relaxed. She was in the hospital for one day and then she was home. This was despite a very large boy, weighing nine pounds twelve ounces. Despite this large baby and the recency of the childbirth, she moved physically with ease and seemed quite comfortable. The HV then talked about a series of other questions. She asked about the baby's weight, what the weight was when the midwife had been there last, which was the day before, whether the baby was regaining his initial weight, the mother's health status, her employment status (not working), the father's employment status (not working), the mother's age, the father's age, and so forth. All of this information was put down in the baby book that the nurse was preparing for the mother. (A parent-held record.)

She discussed breast feeding the baby. The mother talked about how she was breast feeding the baby now, four times a day. She would wake the baby up to take the breast because she was trying to help the baby move as quickly as possible to sleeping through the night, and indeed the baby was waking only once a night already. She had breast fed her other children until they were about 6 or 7 months old and expected to do the same with this baby. She was not offering the baby any water as yet, because the baby was satisfied with the breast milk and she felt that this was better for the baby and the HV agreed.

The HV asked questions about whether the mother intended to go to work. The mother indicated that it was not her plan at present. The HV asked whether she was on Income Support (public assistance) and the mother said yes. She asked whether she had registered the baby's birth and the mother said no. The HV asked whether she knew where to go to register the birth, and the mother said yes, that she did.

The HV discussed vaccinations and explained that they would begin when the baby was 2 months old and there was some discussion about when the older children had had vaccinations and where they had them. At this point the nurse asked whether the mother would come to the clinic where the general practitioner was or go to the nearby clinic, and the mother responded that she had used the latter for the two older children and liked it and found it convenient and would go there. Thus she preferred this nearby health center to where the general practitioners practiced and where this HV was. In effect she was telling the health visitor that she would go for health care - for well-baby care - to a clinic where this HV did not go regularly. If the child became ill, however, she would have to go to the general practitioner. The HHV asked if she had any help with the baby. The mother explained that her own mother had come to stay with them and had just left the day before. She also talked about her husband and said that he was very helpful. She said that her 8 year old daughter was wonderful with the baby as well.

At that point the nurse stopped to talk to Harry and to his friend, who had been playing with a couple of plastic tennis rackets. They had a soft ball and tennis racket and were getting uncomfortably close to the baby in their play. Noticing this, the mother pulled the baby chair over to one side and told the children to move further away when they were playing. The mother talked about her older little girl, Alice, and said that she was doing very well in school and was very bright. She said that the little boy had been in a play group and had not liked it, indeed had disliked it so that she had to withdraw him. Nonetheless, he had recently begun a nursery school class and was delighted with it. He and Kelly were in the same class and would be going shortly for the two-and-one-half hour session that was from 1 o'clock until 3:30.

Essentially this visit was used for the HV to make a quick assessment of the baby's development and the mother's state of mind as well as what was happening with the other children in the family. At no time did she examine the baby, remove the baby's clothes, look the baby over carefully, spend time attempting to in any way touch the baby or assess it except for a quick look at the baby's eyes and skin color, an assessment as to whether or not he was jaundiced, and measuring the circumference of his head.

In this visit the HV concentrated on obtaining information from the mother and giving standard information in return. Thus, among other things, she made sure that the mother knew that she had to register the child's birth, and then could claim child benefit. She made sure that the mother knew how to do this or at least had the information for doing it. She provided information as to when vaccinations were to begin and what was involved. She talked about clinic hours and made sure that the mother knew where she could go. When the information gathering was completed she asked the mother if she had any questions. The mother asked for information about where the family planning clinic was and when it was open. The nurse asked if she had been on the pill and the mother explained that she couldn't take the pill because it gave her migraine headaches. She needed something else.

At the end of the visit the mother agreed that she would go to the clinic within another week or two, during the regular hours and she would get the follow-up examinations there. The HV made no plans to see the mother again but subsequently told me that she will monitor whether the mother attends the clinic over the next six weeks or so and if she doesn't she will call her. If the mother doesn't show up in time for the vaccinations then there will be both a telephone follow-up and a visit. Otherwise she will assume that this competent young mother of three can follow-up with the clinic itself. She also gave the mother the baby book with the information and spent a few more minutes talking to the little boy. After we left she explained that by and large the new mothers visit the clinics weekly from the time their baby is born until the six-week first medical check-up and even visit fairly frequently afterwards. Mothers who have had one or two previous children may visit less often.

The HV said that most of the mothers in this area were on Income Support. There were two problems with their returning to work. One had to do with the fact that there was currently a high unemployment rate and the second was a more serious problem, the shortage of childcare. Although there are private nurseries in the area they charge about £ 150 a week and there's no way women like these mothers would be able to afford that kind of money. On the other hand, places for the care of infants and even toddlers were available only for children defined as being at high risk or in need of protection, and that too was not true for most of these women.

The two vignettes above are based on health visitors with rather different bases. One is based in the health center itself; the other is based in a general practitioner group practice.

A local well-baby clinic also serves as the home base for three health visitors who work in the clinic and do home visits within the community. It is the clinic that the new mother just described will come to. It covers a district in Islington that has about sixty babies a year. Each health visitor carries about 200 family cases. The caseloads are mixed. One health visitor carries a caseload that is 100 percent council tenants (in U.S.

terms, tenants in public housing projects); a second has about half private owners and half council tenants; and the third includes some professionals as well as some council tenants.

Each HV has a program plan for her own caseload with the most specific being that of the relatively young and new nurses. A typical schedule involves a visit at about ten days after birth. This is a visit that is carried out when the entire family is present, usually the father, often grandparents as well as the mother and the baby. The second visit is carried out when the child is 1 month old, usually at a time when the family supports have gone to their own homes and when, if the mother is likely to be depressed, it will become visible. The third visit is at 3 months of age and focuses on preparing the baby for weaning. The fourth is at 6 months of age and focuses on significant changes and physical development and provides the first real opportunity for the nurse to asses developmental lags. The fifth visit is projected at one year, which is another important developmental phase and then two years is the cut-off point. The child is always seen at 3 years of age for the final developmental check-up that is required.

Several HVs pointed out the declining need for routine visits at home for most new babies and their mothers. There have been major social changes that shift the need for such visits. More women are working, more children are in out-of-home childcare, and more parents know about normal child development from the media. On the other hand, special arrangements can be made to meet the needs of working parents. Thus, although before health visitors used to visit at home on an unannounced and unscheduled basis, that is no longer the case, since more and more women are out of the home. If the mother is working, the HV can schedule a specific appointment for visiting at home. And, of course, another option increasingly is having things done within the clinic. Moreover, if there is a nanny or a child minder, she can be involved in lieu of the mother.

The concept theoretically is that the health visitor monitors the child until the age of 5, but in real practice it is until the age of 2 and from then on whatever visits are made are made at the clinic. Almost all parents accept the offer of a health visitor and none could remember being turned away for the first or second visit. However, if that were to happen, they could not insist. If a parent did reject the offer of a visit and there was some reason to suspect severe neglect or abuse then Social Services could be called in.

Typically the HV works a 9 - 5 day. They usually come directly into the clinic at 9:00 and work in their office until 10:00 doing paperwork, responding to telephone calls, and making telephone calls. This is usually the time they set up future appointments if they are not already scheduled. It is also the time that they respond to phone calls from parents who have concerns or want information about something that is happening with their child. They then go out on home visits, most of the time returning to the office at 4 o'clock for another period of paperwork and phone calls from 4:00 until 5:00. However, health visitors also participate in regular clinics at the clinic. For example, there are two baby clinics that meet each week at the clinic, one is a drop-in clinic and the other has a physician who provides the vaccinations and developmental check-ups. There are also some group meetings, although not as many as they would like to have in this particular clinic. They are also involved in case conferences with other professionals, including social workers, teachers, psychologists, and so forth about children on their list. The HVs also mentioned some of the special kinds of problems they see, among them speech problems, which they believe are a result of the child being exposed to two languages, one at home and one at school. They have a speech therapist but with the recent cut-backs in funds there are delays in gaining access to her.

Recent research indicated that health visitors today spend much less time with clients today than they used to, about 50 percent of their time now. They can see about five to six families per day. This is fewer than previously in part because of the increased amount of paperwork.

In contrast to the pattern of the health visitor's schedule, the physicians make their check-ups in the clinic when the baby is 6 weeks old, 3 months old, 7 to 8 months old, 1 year, 2 years, and 3 years.

As noted earlier, should the child be ill, he/she would be taken care of by the general practitioner in the group with which the family is affiliated. In short, these child clinics and health visiting programs are in the "well-baby" category; however, the fact is that we were told at a number of places that the doctors in the clinics actually bend this rule and may very well see a child who is mildly ill, but they will not prescribe medication.

Contrary to the concerns expressed by some HV experts, these three health visitors did not see any competition with the general practitioners about surveillance of children. They made it clear that they preferred the general practitioner to do the inoculations, although they can be trained to do so. The one assigned to a general practitioner practice felt quite comfortable because the general practitioners are glad to have the health visitors deal with social problems that exist for the clients. General practitioners are paid for the surveillance visits and need high up-take but they are glad to have health visitors doing the actual field work on their teams. Nonetheless, in subsequent discussion, relating not to the general practitioner practices with which the health visitors are affiliated, but with relationship to the general practitioners who do not have health visitors in their practice, one HV made it clear that she saw very little cooperation and liaison with the general practitioners; she saw them as not very related to the families and their needs.

At another Health Centre adjacent to a nursery school visited earlier, we met with an HV and the nurse team manager, and had opportunity to observe the work of a HV who was seeing people and the related work by the general practitioner in the health clinic, a woman of Chinese background, as well. This community health clinic is in a cluster of very attractively built and imaginatively designed buildings. In contrast to what we had seen at the other clinic, here there was a spacious waiting room with a quadrangle of chairs, in the midst of which was some very nice play equipment for infants and toddlers, comfortable offices, well-lighted and decorated corridors, and a very nice room for the HV, and another for the doctor. There were several such rooms. The only crowded space seemed to be the immunization room.

In a preliminary discussion with one HV, we learned that they have 3.5 full-time equivalence HVs and another 2.6 in a large general practitioner practice which has five to six general practitioners. In other words, there is a good deal of job-sharing, part-time work, etc., making up these loads. The HV also told us that as nurse manager she could have come from a number of the other nursing backgrounds, of course. In general discussion of what was going on she talked about a campaign to increase breast feeding among the working class, which seemed to have abandoned the practice even while middle class mothers were increasingly adopting it.

The area in which this clinic is located is a mixed area with a large Irish population but also with a large Afro-Caribbean population. There are people from Uganda, Bengal, and in the last two years there has been a large refugee population as well as a large homeless population. Finally, as we had been told previously, there are some homeless people "dumped" here by other boroughs.

This clinic serves a constituency that has 250 births a year. A typical HV load would be 250 families, with each worker getting on average five or six new babies a month. In addition, they offer a variety of parenting groups and can provide information and advice more effectively, they believe, at least for some mothers, in such groups. People who have fewer major problems seem to come to these groups more easily.

The HV's have also been experimenting with a "scoring system" that would help them identify postpartum depression and other high-need cases. (What we would call a risk assessment procedure.) Thus, they are managing with creating groups and networks, one-to-one counseling, support groups, and using referrals. In general, therefore, the pattern now is that after the routine first visit following childbirth people would be coming to the clinic for check-ups, except those selected for more home visiting. A second home visit, if there is one, would be determined by the case situation. Many HVs do a second routine visit after about a month because they are interested in developing a trusting relationship and getting to see the family somewhat more under more routine circumstances. That does not mean that people are not urged at the same time to begin coming to the clinic. If a new mother does not come in at all or is not coming in very often they might decide to make additional home visits. However, there are no local guidelines regarding a specific pattern of visiting.

The assessment is much more individualized and client-centered, and they are pushing for quality, not quantity,

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differentiating the patterns by need. In effect, they have been doing more and more in the clinic with client visits and visiting less at home. They also consider how hard it is for women to get here and whether that should affect the visit. On the other hand, for some women coming to the clinic is clearly an outing and they like to come. This is an area in which everybody served is within walking distance and mothers would not find it hard to get here if they want to.

The child health clinic operates three afternoons a week with the clinic doctor, the clinic nurse, and two of the HVs. These are drop-in arrangements and they found that it cuts the waiting time, in contrast with routine appointments which are often not kept and which lead to poorer use of time. When the parent arrives, usually the mother, she hands in the "parent-held record" which is the record which the HV writes in as well as the parent with regard to the baby's development. The receptionist takes the record which then follows the parent and the child throughout all of the visits at the clinic - the HV, the general practitioner, and so forth. At the end of the day's visit, the record is given back to the parent with indication of which check-ups have been carried out, which vaccinations given, and so forth.

The HV sees all of the mothers and children who come to the clinic. The general practitioner sees only those who want to see her or those who are scheduled for vaccinations. However, the nurse gives the actual vaccinations after the general practitioner sees the baby. The general practitioner will also see people at HV recommendation, as was demonstrated subsequently. About fifteen to thirty people are seen in each clinic session. They indicated that although they do not do routine scheduling because they had 60 percent "no-shows" and cannot cope with emergencies, that is not the only pattern that is possible. They like the drop-in pattern here. This arrangement seems to make it possible for a family to be served completely in about a half-hour. However, the 3-year check-ups for toddlers take about twenty-five minutes. They therefore schedule them for special times as they do the two-year check-ups. They also schedule separately the seven-month hearing check-ups, for which they have a very special room and equipment.

One HV, a red-headed Irish woman, in her late forties, had a business-like approach, warmth, and an enormous amount of experience on which she drew both for the discussion and for her work with the families. She talked first about the routine first visit, ten to fourteen days after birth, and summarized what she covered. She was interested in the mother's health, her support system, how the mother is coping with feeding, the situation of many of the single mothers as partners come and go, which mothers are not free to share, and lack of trust initially of the HV because of their Income Support status.

She discusses diets, clarifies the parent-held record, defines her work somewhat more. If the baby is awake or if the mother requests it she will examine the baby but (unlike the Danish HVs) will not do so routinely. In that the midwife would have previously weighed and measured the baby before discharge (as part of her home visit), the HV does not feel that she has to do it. The one thing that she will do is measure the head circumference, a very important indicator. Also as part of this first visit, she reviews the "equipment" that the mother has, discusses accident hazards, exercise for the mother, and gives the mother the excellent nationally-published pamphlet called "Birth to Five". She's specific about crib death, the dangers and how to avoid them. She asks about siblings, talks about sibling rivalry where relevant, clarifies the content of the pamphlet on immunization, and discusses the time of the second contact. She does not make many referrals on this first visit. She also clarifies whether the mother has registered the baby's birth, whether she's applied for child benefit and knows how to do it, and spends some time explaining the role of the HV. She advises first mothers to come to the clinic weekly and most of them do so. Where mothers of second and subsequent children are concerned she's more likely to leave it up to them. She pointed out that HVs used to do a four-week visit at home designed to pick up on postpartum depression of the mother but that increasingly even that is being done in the clinic. Most referrals at this stage would be made to welfare rights advocates with regard to claiming possible entitlements to Income Support, Family Credit, Child Benefit and so forth. There also may be some checking of the vaccination status of older children if there are siblings in the family.

The six-week visit is carried out almost routinely at the clinic now as are all subsequent visits. Almost all mothers come for this visit and out of her 250-client caseload only one did not come and that was a case of a postpartum depression that she picked up subsequently. For all of the check-ups the clinic nurse weighs the baby and measures the baby. The HV responds to a variety of parent questions and reviews the parent record. She will check the baby's responsiveness at this age, whether the baby is small, whether the baby is smiling, and whether the baby responds to a voice. Both the general practitioner and the HV record this information on the parents' record. (Here it was pointed out that all babies born since June 1991 have a record that the parent keeps in contrast to the prior records kept by the HV and the general practitioner.)

If the HV has noted either at the first or second home visit that there was some kind of problem, she might have decided to continue home visits for some time subsequently. If, however, there didn't seem be any significant problems, she would give the mother a clinic appointment and then monitor whether or not the mother keeps it. If the mother doesn't show up in the clinic as expected the HV will call her or will visit. Here the HV pointed out that in this borough only 3 percent of the children are child protective service cases and there are a small number additionally that are potentially at risk. Such children are visited every four to six weeks at home during their first year.

Vaccinations are given when the baby is 2, 3, 4 months old. At the age of 7 months a hearing test is carried out; at 8 months a vision test, and so forth. At 13 months the MMR (Measles-Mumps-Rubella) vaccination is given. They have now eliminated the 18-month check-up and it is carried out at about 2 years usually but this HV prefers to see the babies at 18 months because she feels that it is an important developmental phase with regard to speaking, toilet training, safety, and so forth.

Parents come to the clinic as they wish, often using it as a kind of neighborhood socializing place. At the time of the first visit the mother gets the name and telephone number of the HV and is told what hours she works and when she can be contacted by phone. Many of them in this area, however, do not have phones and they are told by the HV that if they want to they can come in on a drop-in basis. Thus, the HV said that she would explain that she is usually in the clinic between 9:00 and 10:00 in the morning and between 4:00 and 5:00 in the afternoon and if there is something urgent she will try to make time to see the mother.

We sat through the HV's session with an Afro-Caribbean mother in her twenties with her 13 month-old child. The HV reviewed the routine with the mother and showed the results of the weighing and measuring, relating it on her chart to existing norms. She told the mother that everything looked fine. She then asked how the child was eating, whether she was getting her vitamins, etc. The mother said proudly that the child was now completely on adult food. She was asked if she had any worries about the child at all and then she told the HV that she had taken the child to the hospital because she felt a lump at the back of the skull and the baby did not seem to be acting right. She said that what she was told was that one side of the skull was developing faster than the other. The HV looked at the parent-held record and said that it had not been noted there at all. Clearly the mother was worried about this and the HV said that she would arrange to have her see the doctor at the clinic. The child certainly seemed well and the HV said as much. She asked about allergies. She asked if the mother understood the MMR inoculation and gave her a form to sign to give permission. She also explained the possible reactions at various points over the next several weeks to the various parts of the vaccination. She then talked in more detail, asking about what the child was doing, and learned that the child had been walking since 10 months. At that point she spent a fair amount of time explaining the importance of safety for a child who is physically active and suggested that the mother get down to child-height in the apartment, particularly in the kitchen, to see what the hazards were.

She then asked the mother whether there was anything else she wanted to ask her and the subject of childcare came up. The mother had already listed the child for a place in the nursery school and the HV said that they had recently had a visit from the under-5 nursery worker and was told that there are very few openings. She asked the mother where she had registered herself, gave advice about registering elsewhere, and asked what it was that the mother would be doing when the child was in care. The mother plans "to return to college in September". And she will have proof of that next week to be used in connection with the childcare application. It developed that what she planned to study is hairdressing. The HV suggested that she go to her own

HV, and fill out appropriate forms to get some further aid on childcare. She also warned her that she might not get a place in a center and therefore explained the child minder system. The mother knew about this, and had been told already that she was fifteenth on the child minder list. The mother signed the permission for the immunization and was told that there would be no more immunizations until the child entered school. She told the mother to come back when the child was 18 months old but said that if she was in a childcare center at the time it would not be necessary because she could be examined there.

This 13-month old little girl was a very sweet, placid little girl who sat quietly in her mother's arms and smiled responsively when we made gestures towards her. What was interesting was that according to the mother she was very active physically, had already been walking for three months, but was quite content to be held and not fuss during the examination. She responded to the HV when the HV talked to her and held her for a moment and she responded to us as well. She was well-dressed, clean, and clearly well taken care of. Although the mother seemed somewhat depressed and constricted in the interchange with the HV, she was responsive to the baby.

We saw this mother and baby again when she was seen by the GP. Among other things the GP asked her whether she was still breast feeding, and the mother explained that she was giving the baby bottles but with breast milk and was in the process of making the transition to cow's milk. The GP encouraged this. She asked her specifically about certain foods, such as yogurt, cheese, meat, etc., and was clearly probing for allergies. Apparently all was well as far as the mother was concerned. She went over the same vaccination material that the HV had done earlier and also explained the side-effects. She then asked the mother about the lump on the back of the baby's head. The mother repeated the same information she had given to the HV and the GP examined the baby. She said it was all quite normal and explained the development in much the same terms that had been used by the mother but in slightly more sophisticated language -- a matter of differential patterns of growth.

Next we observed a second family, a Somalian family in which there are three children, but the youngest, a baby, was at home, apparently ill, although expected for a visit on this date. The two who were present were born respectively in November 1988 and January 1990. The mother was wearing a shawl, had a coat on over a native costume. The two children came in and began to play with some of the toys on the floor of the doctor's office while the doctor talked for a few moments with the mother. The mother obviously did not speak English and the doctor was both talking simply and gesturing. She then took the smaller child and looked at the response to the TB test, and found that the results suggested that the child might have had TB at some point. She then tried to explain simply that the child should have a chest x-ray, would not get any further inoculation today, but she would write down and arrange for a hospital visit for the x-ray if the mother wished. All of this was explained simply and the mother gave agreement. She then examined the other child whose results were negative and said the child would need an inoculation. She said that she would do it now. She asked again about the baby, was told she was being cared for by the mother's sister, and the doctor repeated that she will need to see the baby. At this, the GP went with the mother and the two children to the small inoculation room.

Although the mother clearly was having difficulty in communicating and seemed frightened, the children were relaxed, spontaneous, self-assured, and were exceptionally tall for their ages. The children were dressed as appropriately as any other 3 and 1/2 and 2 and 1/2 year olds would be. Nor, despite the fact that they knew that they were going to have vaccinations, were they seemingly frightened. One had a sense here that the children were already making a transition to Britain while the mother had not even begun this.

FAMILY SUPPORT SERVICES

1. A Center for Under-fives and Their Families

This Family Center is part of the development now being encouraged by the 1989 Children Act. The legislation mandates family centers for all children and families in need or at risk but does not provide significant resources for their establishment.

The British family center developments predate the 1989 legislation and stem from the early 1980s, largely from one of two bases. One group of family centers emerged from children's residential facilities, which in the early 1980s found themselves with less and less to do as the philosophy for placing children in need of protection was reoriented and community care and family preservation, in U.S. terms, became dominant. Many of the agencies that were responsible for children's institutions looked for alternative program initiatives and turned to an emphasis on community-based, family-focussed, new strategies for working with at-risk children and their families.

The second source is the childcare programs which expanded during the 1980s in response to the increased labor force participation of women and the growing demand for childcare. Since the child care philosophy increasingly stressed integrating care and education, new child care programs or new perspectives on existing programs were developed. At the same time there was a growing conviction that these should have families involved and be more family-focussed.

Thus, the two parallel streams of social service (and child welfare) concerns and childcare concerns led to the development of more family-focussed programs and the British concept of a family center. These closely resemble the U.S. family support programs in that they vary in auspice, in range of interventions, and somewhat in philosophy, are targeted on high risk and vulnerable children and families, on young parents and young children, and, are equally diffuse in the way in which they "intervene" and in their impacts.

The community in which the Center is located, has a population of about 52,000 and many of the people here come from an industrial working class background. It was a heavy industrial and mining town and experienced severe unemployment in the 70s and early 80s. It is described now as a "women's working town" because many of the men remain unemployed and the women are working irregularly or on off hours or on shift work in the service sector.

The Center has an unusual physical setting. It is located in what was a residential area in this heavy industry community. The core is a very large, old, horseshoe-shaped brick building that once housed a nursery, and later a health clinic. Adjacent to it and linked to it through a doorway is a very large abandoned school which the Center has partially taken over making use of a large gymnasium, and much of the rest of the downstairs for a playgroup and other activities. Upstairs, are the two group meeting rooms, one of which is also used for an under-2 group (an infant/toddler group) and once a week for the HV who holds a clinic there. Because of problems resulting from a fire and subsequent repairs and maintenance, most of the building will soon be torn down and only the gym will be preserved; but it will leave the Center with a larger outdoor area for play. The outdoor space is adequate now, but not ideal, with concrete play areas as well as grassy spaces.

The Center has an extraordinarily strong child orientation, deriving from its childcare base, and therefore goes beyond the U.S. family support centers in that it includes a child care program at its core. It is a family support and parent education center with a day nursery (child care center) at its very heart.

The director is a charismatic woman with a strong commitment to active parent involvement and empowerment.

The center opened in 1983 as a "demonstration project" in the combining of nursery school/day nurseries and social services. The funding and administration are jointly shared between education and personal social services, and there is meticulous efforts at implementing a balanced joint administrative and policy making perspective.

In the past, the center was open all year round, but since 1992 it closes for two-weeks each summer so all the staff can take their vacations at the same time. A playgroup, however, continues to be operated then if parents want it. The center also closes for several days at Christmas and at Easter, as well as on all bank holidays.

2. The Child Care Center

Some facts about the day nursery are here summarized briefly: There are thirty-five children enrolled in the morning session in six groups with a maximum of six children in each group. Thirty-five children are enrolled in the afternoon, in the same pattern, with some overlap in participants so that between sixty and seventy children can participate on any one day. There are no rigid expectations about length of day. This is a community with very high male unemployment rates which peaked at 44 percent in the early 1980s and are now between 20 percent and 25 percent. There has been a major shift in gender roles in this very traditional working class community, as more and more mothers have gone off to work to help support their families, but usually in unskilled, poorly-paying, service sector jobs. As a result, they often are home during the day and work the evening shift (5 p.m. to 10 p.m) or night shift. Thus, some children remain at the Center all day, some leave before lunch, some arrive after lunch. Some come in at 10:30 and stay until the end of the day. In short, because of the lack of work during conventional hours the Center does not need conventional hour nursery coverage.

Most of the children are between 2 and 4 years of age.

The nursery staff is made up of five fully qualified "nursery officers", two nursery school teachers, and a group of five other staff who have miscellaneous experience and qualifications. There is a cook for twenty-five hours per week, a kitchen assistant for about half that time, and a "dinner supervisor" for about seven hours per week. There is a resource center with a manager, somebody who staffs the family (drop-in center) room (thirty hours per week), and a group work leader for about twenty-two hours per week. There are two clerical assistants part-time. The full complement would be about twenty-five in staff and they have the equivalent of about twenty people now. Each child care (or family) worker follows ten children very closely (four in each session including two who remain for the full day); this worker is known as the key worker (see earlier, child care discussion).

The director pointed out that centers tend to hire staff from one or another discipline or training orientation, either education or health care, for example. Some emphasize staff with nursery training, some teachers, some emphasize the HV point of view and some the nursery training. Here they take people from all these backgrounds, and other qualifications such as psychology training as well. In other words, they let all the "core" early childhood disciplines in and cross borders in the programming. They find this helpful and enriching.

The center opens at 8:30 in the morning, closes at 4:15 in the afternoon, but most of the children leave before that. Occasionally a child might come earlier because of a parent's working schedule. A large group of children come later, at 9:00 or after that. Various parent groups meet mornings, afternoons, or evenings, depending upon schedule, subject, and preference.

Breakfast is not provided routinely because the director discovered that some children were not eating breakfast at home with their parents in preference to having breakfast with their friends. Parents objected to this, and it was an added expense for the Center. Now, children coming before 9:30 are offered breakfast; they can go into the kitchen and sit on a high chair with the cook and have breakfast there. Most of the children eat breakfast at home now, but they have a snack at the Center quite early and snacks are offered at several other times during the day.

The child care day is largely unstructured in the sense that the staff try to follow the child's lead, the child being free to play indoors or outdoors and to play in various parts of the room where the group is meeting. The key worker makes it a point of remaining close to the child. Twice during the day, once in the morning and once in the afternoon, the key worker will initiate activity (11 a.m. and 3 p.m.) which might take the form of story reading, discussion of something on the children's minds, asking the children's opinions about something, etc. In this we are reminded of the Danish approach developed by pedagogues. The children eat in groups of six with their key worker.

There is ample physical space and an enormous amount of active play in the form of kicking balls, riding carts and various other vehicles, climbing; and there is a large amount of water play. The children are active, independent, interacting with and talking to one another frequently. Yet at many points there is an adult with a child in her arms, on her lap, and individual reading or helping with an activity or project.

The family workers know the children and are responding to them with a very conscious awareness of where they are in their development, what has been going on at home, what the problems are and the needs are. This is in part supported by the fact that these are not parents who merely drop off their children in the morning. Since most of them are not on their way to work, they tend to stay around a while, talk to the family workers whom they know quite well, describe what has been going on with the child, and hear about what the child has been doing in the center. Parents and the family worker are teamed up in behalf of the child and the child is relating to both. They strongly believe in children's rights and assertiveness and adhere to the commitment to follow children's needs and to develop their assertiveness, thereby giving them power.

There is no formal post-lunch rest period in the child care center. In contrast to most other child care programs even the rest period seems to be left up to the child's particular pattern and needs. Some children want to rest and they go into a quiet room to do so, but most of the others are up. This also may have to do with the fact that most of the children leave either before lunch or just after lunch and only a small group stay for the "full day".

In addition to the usual group rooms subdivided for the usual activities and very well equipped with age appropriate toys, books, and so forth, the Center has some unusual and particularly imaginative large play equipment. For example, in the wing that includes the gymnasium and the parent meeting rooms there is a "jumping room". It has protective mats on all the walls, a trampoline, a large number of rubber figures that are anchored to the floor and can be jumped on and hit, a large low crib-like construction in which children play with a myriad of small brightly-colored plastic balls, and several "mattresses" on which children can jump and play. There are large brightly-colored plastic cubes, squares, rectangles, poles and tubes that the children use either as punching bags or to jump on. There is nothing in the room except these things and the children have the possibility of totally uninhibited play for the amount of time they are permitted here. Here too, about six children at a time come to play and clearly are wildly enthusiastic about the space and the equipment.

In the main building there is another unusual activity room. This is called a "soft room" or "snoozeland". It is a Dutch-designed piece of equipment made initially for handicapped children but used in this center for normal children as well. It is a small room in which the walls are padded white plastic and the floor is cushioned and also padded white plastic. There are three white beanbag-type chairs also covered in this white plastic. Children take their shoes off before coming into the room. There is a scene projected on one wall of mountains, sky, space travel, and on another wall of water and fish. There are tubes of water with colored lights. There are fiber-optic cables which can be wrapped around one for fantasy purposes. There are several kinds of squares and circles with lights that expand or contract or take different shapes and forms, all in different colors. And there is soft music, often sort of oriental. There are different music tapes, but all are quiet, meditative, and in some ways hypnotic. The door is closed after the children enter and it is an intensive, relaxed experience. Some children have asked what day it is or where they are when they leave.

The "soft room" is used for multi-handicapped children and made available to other institutions in the community for special visits by children with special needs. It is also used by the children at the Center. Nursery school children may request access and when they have had a particularly stressful time at home over a weekend they often ask to go into the room on Monday morning.

Great stress is placed on "record keeping" and documenting the child's experience in the program. It would appear that there is some effort at copying what goes on in Reggio Emilio but in a much more structured and somewhat artificial level. A book is begun as soon as the child enters the program entitled "A Celebration of My Achievements". Staff, parents, and children either write in the book or tell the staff what to write. Samples of the child's work are inserted as well. When the child leaves the program to enter school the book goes home with the child as a "souvenir" of the program. The book contains vignettes from the staff members about what a child has done and they sometimes contain little statements from the parents about what has been going on at home, which may or may not be related to the experience in the nursery. It is regarded as a shared book from the beginning. It also has basic information so that it is known who can pick up the child, whom to call in an emergency, what inoculations have taken place, who his/her doctor is, etc.

Before children enter school, when they are 4 and leaving the program (children qualify for school as long as they become 4 before August 31 of the year they will be entering school) there is a formal program of preparation for school in which the schools participate by inviting the children and their mothers to come and visit once, twice, or three times in the spring of the year before the child enters. In this program they discuss the concerns regarding the transition to school, getting lost, being bullied, being approached by strangers, and so forth.

In addition to the child care center (day nursery or nursery school) and other child care activities (to be described later) including the drop-in center, a play group, the "*crèche*" care services, the second core component is the parent education and support program. As the program has developed it has expanded from what was originally a small parent group program to what is now a very large and active parent program.

The program has some qualities of a settlement house for young families and children. The Family Room is an important place where parents can come with their children and participate for the day in whatever way they wish in a room with equipment and one paid worker. It is a drop-in facility for mothers and children, but there are some people who come many days and indeed one has been known to come full-time all week for thirty-seven hours. When noontime comes, the staff person there prepares a simple meal for parents and children and they can have it for a very small fee. If they are temporarily short of money they also may have credit. At one end of the room is a couch and several comfortable chairs where the mothers tend to sit with their babies or among themselves, have coffee or tea and talk. At the other end was a small child-sized table with several chairs, toys for children, a playpen, and so forth. Here the babies can crawl around, the toddlers can "toddle", and the children can play with one another. Sometimes the children play with each other and sometimes one or two mothers will go over and join the children who are playing. Thus there is opportunity for parents (overwhelmingly mothers) to get together with one another, socialize, but yet supervise their children.

Two upstairs rooms at the Center are devoted to more formal parent groups and related activities, with comfortable chairs and couches arranged in a circle to facilitate discussion. The rooms have space for groups of about ten and the participation usually is six to ten in a given group. The rooms are light and bright. One room has space for child play as well, since it is the room used for the Mother-Toddler group on Tuesdays as well for the public health nurse who does the clinic that same day, also in that room. The other room has a table with library materials, pamphlets, books, etc., which the parents want to read. There are bulletin boards which tell them about educational and other activities. Most groups meet weekly, but some meet on alternate weeks.

Many of the group leaders now are parents who themselves have been members of these groups. However, many of the staff members also lead such groups. At present there are between twenty-four and thirty different types of groups in operation. Included among these are the following:

- under-two group
- the preschool child
- riders' group
- male survivors' groups (for men who were abused as children)
- men's group
- youth club (for adolescents)
- after-school club (for five- to twelve-year-olds)
- single parents' group
- baby group
- special needs support group

- More About Eve (a women's group)
- handling stress
- living with babies and toddlers (a formal course provided through the open university)
- aerobics
- relaxation
- a special needs group for parents and children
- keeping in touch (for parents who are divorcing to let them know about the importance of staying related to their children)

Every ten weeks the staff and parents together review existing groups and decide which of them should be ended, which should continue, and if there is a need for new ones. If the parents want a new group, it is initiated. There is increasing interest in formal education and opportunities for adult education courses. Indeed the parents who are active volunteers in a lot of the programs at the center increasingly express some interest in having payoff for themselves by being given opportunities for formal education and specialized training.

One of the more popular "courses" is an assertiveness training course for grownups and a special assertiveness program that is carried out for children. One mother whose young son participated described what she thought of the results, saying, "I now have a very assertive little boy". Although the results are not always easy to live with at home, parents favor it and think it good for their children. But it does mean that when some of the children go to elementary school they are described as "difficult to deal with". Sometimes they ask for better activities and refuse some of the things that are suggested. They have a reputation in the community, which the parents and staff all regard as positive although it creates some problems for the people in the school.

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Parents clearly have a sense of what Americans would call "ownership" of the whole program. They are proud of what has been accomplished and they normally and without much fuss are participants in the planning, decisions, and all the extra activities. Thus, the staff do not meet without the parents having access to the meeting as well. Except for one two-day training program each year, no staff training courses are carried out without the possibility of parent participation.

Most parents are eligible for these programs through the social service priority system which allocates proportions of the places in different authorities to parents with special needs, defined as poverty, family structural problems, etc., or difficulties manifested in the children. These include abused and neglected children, children at risk, etc. Despite the fact that the Center serves what are described as many hurt children and parents, one does not sense any of this in the atmosphere. Staff do not patronize people and there is no sense that they are dealing with incompetent people. Indeed, the parents are treated as peers and respected. This is not to say that some of the children do not seem fragile or troubled and some of the mothers depressed. There is a nurturing group available to young children for whom there is not space in the regular group. This group is made of up of children who have been particularly referred as troubled by HVs, social workers, and other personnel who deal with them. The group is intensively staffed with a treatment orientation. In contrast, those who participate in the parent education activities, the play group, the drop-in center, are all self-selected and voluntary. Thus, they represent a somewhat broader socioeconomic group and a larger geographic group, since they can come from outside the catchment area.

Some of the other special activities at the Center are the following:

An under-2 (Mother/Infant/Toddler) group meets once a week on Tuesday mornings, with mothers and their babies coming together to meet, socialize, gain some knowledge about child development and maybe see some role modelling as well.

The HV operates a clinic and an informal mothers' group every Tuesday afternoon. Here she sees not only the children from her own register but she also encourages the participation of other mothers with infants and toddlers.

One consequence of having an infant/toddler group on Tuesday mornings and a health clinic on Tuesday afternoons, is that a mother with a young baby will often spend all day Tuesday at the center because it provides a good opportunity for socialization for both child and mother as well as an opportunity to get some health advice and to expose her child to other children.

Home Visiting is another important component of the program, provided by the HV, but more importantly by the Center staff - the family workers. As mentioned earlier, the Center has the system of key workers that characterizes some of the British child care centers, child care workers each of whom concentrates on knowing one child and family well. Apart from the visits to the home during the application and transition period and the spending of an enormous amount of time with the child during the transition period, these key workers also carry out home visits to the families more or less regularly depending on child and family needs.

Each family worker is scheduled to allow a visit to one family each week. The plan is to go to each family every few months. However, at parents' initiative or as problems arise, they may go much more often. The families like these visits and the children "love" them. They are delighted to have their family worker see their home. What is more, they are curious about the family worker and all visit the family workers' homes as well. Most of these family workers live very close to the center, but one is as far as fifteen miles away. In that case, they use the mini-bus, driven by volunteers, for such visits. (It is a municipal requirement that the staff live nearby.) Thus, for the child, the nursery is a very intensive experience. There is the same key worker for two years, a worker who visits their home, and if they are not ready for school at four because of a birth date after August, it may even be for three years. The work is intensive in another sense. The Center has introduced a social work pattern of supervision so that the workers are quite self-conscious and discuss with supervisors what they have been doing.

A consulting social worker also provides service to the families at the Center. Currently a social worker comes in for six sessions per week focusing on preventive intervention in families in which there is some risk of the child's being placed. On Tuesdays and Thursdays the social worker meets with a group of four children referred by other social workers as being particularly in need of intervention. Two times a week she meets with a blind child. Two times a week she meets with twins and their mother in a case in which the mother seems to be having some problems managing the twins.

Special "part-time" systematic staffing of childcare is provided while parents are in parent groups or classes, whatever the hours of the day. This is called "crèche staffing" at the Center. It is all provided by volunteers who receive special training at the Center, are recognized as having this role, and whose pictures even appear on a bulletin board which outlines who the staff are. The crèche workers provide childcare for the same groups each week so that the children whose parents are attending a given group have some continuity with the worker.

Playgroups were first established at the Center about seven years ago. Wednesday afternoons of each week are used for staff meetings and as a result the children can't participate in a nursery program at that time nor are there any special parents' groups. As a result some of the mothers and parents were resentful and decided that they wanted something for their children. Several of them decided that they would organize a playgroup and this was supported by the director and staff. The group was very popular and, although it began by meeting one afternoon a week, it soon moved to an expanded schedule of one afternoon and two mornings, then every afternoon and now it meets on a five day a week basis for two "sessions". One session is a morning session from 9:30 to 11:30 and the second is an afternoon session from about 1:45 or 2 o'clock to 2:45 or 3 o'clock. Twenty-five children participate in each session. This is in effect a parent-operated and parent-staffed activity, supplementing what the child care program provides for children for whom there are no places available. These children also come from a variety of ethnic and racial backgrounds, including Asian, African, Caribbean, Indian.

In a group of thirteen children ranging from 11 months to 3 years, including three children from minority groups, two 3 year-old boys were in very intense discussion at a table in the playgroup room, playing with one another without anyone in direct supervision. An 11 month-old little girl, an interracial child, with a delightful disposition and good physical dexterity was in a walker. She was very mobile and had managed to maneuver herself wherever she wanted to go with great aplomb, attaching herself first to a group of 3 year olds and then to the staff member. In another part of the room there was a man reading a story to four children, two children on a small see-saw, and two toddlers with their mothers. Of particular interest, four children of staff members in the program were in the playgroup, cared for in effect by other mothers. These were all children who would not qualify for the priority list and therefore would not have been able to enter the nursery school.

Once a week there is an "open house" at the Center for children and their caregivers. There is a weekly staff meeting on Wednesdays that lasts for four hours and in fact led to the early development of the playgroups to ensure childcare for that period. Paralleling this on Wednesday morning the regular nursery program is closed and the center is open to all parents with children under the age of 5, to carers, child minders, foster parents -- from the general community. In other words it becomes an open drop-in center for anyone taking care of a child under the age of 5. Some parents whose children are in the nursery program bring them anyway. This is viewed as a device for strengthening links with the community at large, in particular because there is a long waiting list for entry into the program and even the playgroups are not an adequate substitute. There is always a significant group of parents who would like to get their children into the program but who are not on the priority list and cannot be served. This Wednesday morning program is a pale substitute for this but it does help build a constituency for the Center. Some of the children later enter into the regular program and some of the parents or the caregivers subsequently participate in special groups. It was begun experimentally but it has become very popular.

To conclude this description, we note that Britain is and always has been a problem-oriented welfare state with more and more stress on needs testing and means testing. The former is seen in the Children's Act, the latter in its social assistance program. The Family Center developments need to be seen in this context, part of a very limited and still targeted child care initiative, but also part of a new, perhaps grassroots, family-focused social movement.

Although family centers are mandated in the 1989 Children's Act, there are still no extensive developments and there certainly is no uniform model. The Center just discussed is known throughout the professional community in Britain, but it is also relatively unique. In many ways, it is the most similar to the U.S. programs because of the high risk, vulnerable population that it is targeted on, and the settlement house /community development model that it exemplifies - an especially attractive model in the U.S. as well. In contrast to some of the U.S. programs, this family Center does provide on site child care and recognizes the importance of this program as a core component rather than just drop-in child care services. It is beginning to discuss the addition of training programs and employment links as well. Here, too leadership is very important and certainly the director is a charismatic woman. What the implications of this might be for future replications is unclear.

One might summarize a number of special features of this program:

- There is a 50-50 funding division between education and social service authorities with some of the concomitant problems of such fragmented and categorical funding.
- Parent involvement is strongly emphasized in the Center's program. Parents who develop confidence and interest lead groups. There is also parent participation on an advisory board. Parents also can participate in many of the in-service training programs.

- The director and staff are related to and alert to developments elsewhere. There have been visits to Italy and Denmark and there is a planned joint exchange involving Italian child care and family support experts.
- They started with a small playgroup, but it grew, increased in frequency and in size. By now they have a very elaborate playgroup operation. It has its own space, but shares some facilities with the nursery. It is an important part of the total program and has grown largely as an effort at compensating for the absence of a truly universal program and the large waiting list of non-priority children for acceptance in the Center.
- Staff are used very flexibly, both to avoid turf problems and to integrate them into the philosophy and culture of the Center. Thus, for example, the family workers in the nursery very often lead groups or take on other jobs.
- Of particular importance, there are no fees here for almost any of the programs. This, after all, is viewed as a service for deprived people. However, there are small fees for the playgroups and for the after-school program free.
- There are no formal evaluations, but this community, which in the past was viewed as the center of difficult and troubled families, has gradually been upgraded and become more attractive to people, apparently in part because of the attractions of the program. Other people have moved in; commercial and social services are available. Another part of

the county is now described as the place where the most difficult people are.

- Staff have prepared much material with regard to their curriculum: a program for developing assertiveness in young children; a program for making a transition to compulsory school; a curriculum with regard to different types of parent groups. Much of this is an indication of the deliberation and self-consciousness and self-awareness with which they carry out the program. They clearly see themselves as being at the forefront of an important development and want to document what they are doing in order to share it with others.

CONCLUSION

Britain has no explicit family policy, nor a coherent set of child or family policies, and certainly no special policies targeted on very young children. Despite its early pioneering role as a welfare state it is clearly a family policy laggard. It has lagged with regard to gender role changes and policy responses but less so with regard to changes in family structure.

Britain's main child and family policies are embedded in its general social policy which is largely an anti-poverty policy, stressing social assistance and means-tested benefits. In the context of targeting policies on the poor, however, Britain does have a significant child benefit that is more generous for first children than in most other countries and also does well by lone mothers, both working and at-home. Yet its CB has not maintained its real value since family allowances were first introduced in

Britain after World War II and only its health service remains exemplary where children are concerned. It has only recently enacted a parental leave policy under pressure from the European Union (EU) and its policy seems meager and minimalist in comparison with most other countries in the EU. Child care services are inadequate with regard to quantity, quality, accessibility, and philosophy, although there are some signs of improvement and greater responsiveness. There is beginning acknowledgment of the need to integrate child care and education but thus far it seems to be implemented through co-location only, leaving the differences in staff, training, philosophy and curriculum in place.

Britain emphasizes child health policies in the context of its overall National Health Services and provides an exemplary home health visiting service that is targeted on young children and their families (along with the elderly and the handicapped).

Finally, Britain is beginning to develop a system of family support services, but these, too, are targeted only on high risk, vulnerable children and families.

NOTES

1 The best current description and analysis of the British child/family benefit system can be found in Joan C. Brown, Children in Social Security. (London, England: Policy Studies Institute, 1984). For some sense of the British system in comparative perspective, in addition to Kahn and Kamerman, Income Transfers for Families with Children, see also Johnathan Bradshaw and David Piachaud, Child Support in the European Community. (London, England: Bedford Square Press, 1980). Also see the most recent Jonathan Bradshaw et al, Support for Children: A Comparison of Arrangements in Fifteen Countries (London: Department of Social Security, Research Report No. 21, HMSO, 1993). For a U.S. analysis see Lynn M. Ellingson, "Children's Allowances in the United Kingdom." Social Security Bulletin, Vol. 43, No. 10, October 1980, 21-24.

2 The benefit rates are all for 1992, and they are all per week unless otherwise specified.

3 For the best source on the early development of family allowances, culminating in the passage of the legislation establishing the program, see John MacNicol, The Movement for Family Allowances, 1918-45: A Study in Social Policy Development. (London, England: Heinemann, 1980).

4 Joan Brown, Children in Social Security, p. 29.

5 For the best recent analysis of the history and evaluation of FIS, see Joan C. Brown, Family Income Supplement. (London, England: PSI, 1983).

6 For one perspective on this story, see Hilary Land, "The Child Benefit Fiasco", Yearbook of Social Policy, 1976.

7 Shirley Goodwin, "Child Health Services in England and Wales: An Overview", American Academy of Pediatrics, Child Health in 1990: The United States compared to Canada, England and Wales, France, the Netherlands, and Norway. Supplement to Pediatrics, Vol. 86, No 6, December 1990. See also, statement of Shirley Goodwin in Child Health: Lessons From Developed Nations. (U.S. House of Representatives, Hearing Before the Select Committee on Children, Youth, and Families, Washington, D.C. 1990). This section draws heavily on these sources as well as several other articles by Ms. Goodwin and on interviews with her and other written personal communications.

8 National Children's Bureau Highlight, No. 87, January 1989. Community Health Care for Families With Young Children, p. 1.

9 Sheila B. Kamerman and Alfred J. Kahn, "Home Health Visiting in Europe", The Future of Children, Vol. 3, No. 3 (December, 1993).

10 The Children's Act 1989, Guidance and Regulations. Vol. 2, Family Support, Day Care, and Educational Provision for Young Children. London: HMSO, 1991, pp. 18-19.

11 This demographic section draws on: Kathleen Kiernan and Malcolm Wicks, Family Change and Future Policy. (London: England: Family Policy Studies Centre, 1990).; Malcolm Wicks, The British Family: Trends, Policies, and Issues. Prepared for the European Observatory of Family Policies, European Community. 1990; Children Under Five, Fact Sheet # 7. (London: Family Policy Studies Centre, 1989).

12 Gillian Pugh, "Parental Employment and Caring for Children: Policies and Services in the EC and Nordic Countries", Paper Prepared for Conference on Reconciling Employment and Caring for Children Under Three (Copenhagen, Denmark, September 23-25, 1992, Processed).

13 Raimondo Cagiano de Azevado, "Family Policy and the Crisis of Welfare Societies", Faculty of Economics, University "La Sapienza" of Rome. 1992. processed.

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Table A-1

Exchange Rates, Purchasing Power Parities, and ECU Values

In discussing program costs, fees, and salaries throughout the text, we have applied OECD exchange rates for the applicable years. These direct currency exchanges do not, however, suggest a currency's true purchasing power in its own country. The purchasing power parity rate comes closer to that. The reader will note the ratios between exchange and PPP rates.

Exchange Rates and Purchasing Power Parities (PPP)
Per U.S. Dollars ($1), as Reported by OECD

1991

Country	*Exchange, per $1*	*PPP per $1*
Denmark	6.396 (= $ .156)	9.17 (= $ .109)
France	5.642 (= $ .177)	6.52 (= $ .154)
Finland	4.044 (= $ .247)	6.30 (= $ .159)
Germany	1.666 (= $ .600)	2.09 (= $ .478)
Italy	1240.610 (= $ .0008)	1462.00 (= $ .0006)
United Kingdom	0.557 (= $1.700)	0.535 (= $1.58)

1992

Country	*Exchange, per $1*	*PPP per $1*
Denmark	6.038 (= $ .166)	9.94 (= $ .101)
France	5.294 (= $ .189)	6.55 (= $ .153)
Finland	4.479 (= $ .223)	6.40 (= $ .156)
Germany	1.562 (= $ .640)	2.11 (= $ .474)
Italy	1232.41 (= $ .0008)	1485.00 (= $ .0007)
United Kingdom	0.570 (= $1.750)	0.629 (= $1.59)

Source: Sheila B. Kamerman and Alfred J. Kahn, A Welcome for Every Child: Care, Education, and Family Support for Infants and Toddlers in Europe (Arlington, VA: Zero to Three, The National Center for Clinical Infant Programs, 1994), p. 77.

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Table A-2

Average Gross Earnings of Production Workers in Own Currency, 1992

Country	Males	Females
Denmark (DK)	232,000	196,000
Finland (FIM)	123,588	95,784
France (F)	115,200	91,200
Germany (DM)	53,000	37,370
Italy (L)	31,000,000	24,500,000
United Kingdom (£)	14,500	9,000
United States ($)	26,940	17,770

Source: Bradshaw, et al, Support for Children (London: Department of Social Security, Research Report No. 21, 1993), p. 26. These are presented as "estimates". Finland data from government sources.

Table A-3

Demography

DEMOGRAPHY

	Total area thousand sq. km	Population					Age Structure of Population % of total population						
		thousands		per sq. km.	Growth Rate %		under 15		15–64		65 and over		
		1992	1982	1992	1992/91	1975/74	1992	1960	1992	1960	1992	1960	
Australia	7,686.8	17,529	15,184	2.3	1.4	1.2	22.0[e]	30.1	66.9[e]	61.4	11.2[e]	8.5	Australia
Austria	83.9	7,884	7,571	94.0	0.8	–0.3	17.5	22.0	67.3	65.8	15.2	12.2	Austria
Belgium	30.5	10,045	9,856	329.3	0.4	0.3	18.2[e]	23.5	66.5	64.5	15.3	12.0	Belgium
Canada	9,976.1	28,436	24,604	2.9	1.5	1.5	20.7	33.7	67.7	58.7	11.6	7.6	Canada
Denmark	43.1	5,170	5,119	120.0	0.3	0.3	17.0[e]	25.2	67.5[e]	64.2	15.5	10.6	Denmark
Finland	338.0	5,042	4,827	14.9	0.3	0.4	19.2	30.4	67.1	62.3	13.7	7.3	Finland
France	549.0	57,372	54,480	104.5	0.6	0.5	20.0	26.4	65.6	62.0	14.4	11.6	France
Germany	248.6[a]	64,846[b]	61,638	260.8	1.2	–0.4	15.5	21.3	69.2	67.8	15.3	10.9	Germany
Greece	132.0	10,300	9,790	78.0	0.3	0.9	19.4[f]	26.1	66.8[f]	65.8	13.8[f]	8.1	Greece
Iceland	103.0	260	234	2.5	0.8	1.4	24.8[e]	34.8	64.5[e]	57.2	10.7[e]	8.0	Iceland
Ireland	70.3	3,547	3,480	50.5	0.7	1.7	26.8[e]	30.5	61.8[e]	58.6	11.4[e]	10.9	Ireland
Italy	301.2	56,859	56,639	188.8	0.2	0.6	15.7	23.4	68.9	67.6	15.4	9.0	Italy
Japan	377.8	124,320	118,450	329.1	0.3	1.2	17.3	30.1	69.7	63.8	13.0	6.1	Japan
Luxembourg	2.6	390	366	150.0	2.1[c]	1.1	17.7[e]	21.4	68.8[e]	67.8	13.5[e]	10.8	Luxembourg
Netherlands	40.8	15,184	14,313	372.2	0.8	0.9	18.3	30.0	68.7	61.0	13.0	9.0	Netherlands
New Zealand	268.7	3,443	3,183	12.8	1.1	1.8	23.1	32.8	65.4	58.5	11.5	8.7	New Zealand
Norway	324.2	4,287	4,116	13.2	0.6	0.6	19.1	25.9	64.6	63.2	16.2	10.9	Norway
Portugal	92.4	9,858	9,877	106.7	0.0	1.0[d]	19.1	29.0	66.9	62.9	14.0	8.1	Portugal
Spain	504.8	39,085	37,961	77.4	0.2	1.0	18.4	27.3	67.6	64.5	14.0	8.2	Spain
Sweden	450.0	8,674	8,327	19.3	0.7	0.4	19.0	22.4	62.9	65.9	18.1	11.7	Sweden
Switzerland	41.3	6,875	6,467	166.5	1.1	–0.9	16.8	23.5	68.2	66.3	15.0	10.2	Switzerland
Turkey	780.6	59,233	47,020	75.9	2.3	2.4	35.1	41.2	60.5	55.1	4.4	3.7	Turkey
United Kingdom	244.8	57,848	56,335	236.3	0.3	0.0	19.2[e]	23.3	65.1[e]	65.0	15.7[e]	11.7	United Kingdom
United States	9,372.6	255,610	232,520	27.3	1.2	1.0	21.9	31.0	65.5	59.7	12.6	9.3	United States

Notes:
a. 356.9 for unified Germany
b. 80,569 for unified Germany
c. 1991/90
d. 1976/75
e. 1991
f. 1989

Sources: *Labour Force Statistics: 1972–1992*, OECD, Paris, 1994.
Employment Outlook, OECD, Paris, September 1992.

Source: OECD in Figures, 1994 Edition, pp. 6-7.

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Table A-4

The Under 3s in the Countries Studied

Country and Year	Number
Denmark (1991)	180,095
Finland (1991)	193,829
France (1991)	2,250,000
Germany, West (1988)	1,870,000
Germany, East (1990)	611,100
Italy (1990)	1,696,000
United Kingdom (1990)	2,308,300
United States (1991)	11,786,000

Source: United Nations Demographic Year Book, Nordic Social Statistics, Country informants.

Where numbers are rounded, they are approximations for the study years.

Table A-5

Foreign Populations in the Countries Studied

Country	1989	1990
Denmark	2.9	3.1
Finland	0.4	0.5
France	---	6.3
Germany, West	7.7	8.2
Italy	0.9	1.4
Sweden	5.3	5.6
United Kingdom	3.4	3.3

Source: OECD Observer, June/July 1992, p. 10.
Percentages of resident population.

Table A-6

Fertility, Infant Mortality and Life Expectancy

HEALTH II

	Total Fertility Rate		Infant Mortality		Life Expectancy												
					at birth				at age 40				at age 60				
					Women		Men		Women		Men		Women		Men		
	1991	1960	1991	1960	1991	1960	1991	1960	1991	1960	1991	1960	1991	1960	1991	1960	
Australia	1.85		0.71	2.01	80.0[a]	74.0	73.9[a]	67.9	41.5[a]	36.9	36.4[a]	31.9	23.1[a]	19.5	18.8[a]	15.6	Australia
Austria	1.50	2.69	0.74	3.75	79.2	71.9	72.6	65.4	40.4[a]	36.2	34.9	31.2	22.3	18.6	18.3	15.0	Austria
Belgium	1.57	2.58	0.84	3.12	79.1[a]	73.5	72.4[a]	67.7	40.6[a]	36.1	34.8[a]	31.4	22.5[a]	18.7	17.6[a]	15.4	Belgium
Canada	1.80	3.90	0.68[a]	2.73	80.4[a]	74.3[e]	73.8[a]	68.4[e]	41.9[a]	37.5[e]	36.2[a]	33.0[e]	23.7[a]	19.9[e]	18.9[a]	16.8[e]	Canada
Denmark	1.68	2.54	0.75[a]	2.15	77.7[a]	74.1	72.0[a]	72.3	39.2[a]	36.7	34.3[a]	34.2	21.7[a]	19.1	17.5[a]	17.2	Denmark
Finland	1.80	2.71	0.58	2.10	79.3	71.6	71.4	64.9	40.6	35.0	33.9	29.7	22.3	17.5	17.4	14.4	Finland
France	1.77	2.73	0.73	2.74	81.1	73.6	73.0	67.0	42.6	37.2	35.7	31.7	24.4	19.5	19.2	15.6	France
Germany	1.40	2.36	0.71[a]	3.38	79.0[b]	72.4	72.6[b]	66.9	40.4[b]	36.1	34.7[b]	31.9	22.2[b]	18.5	17.8[b]	15.5	Germany
Greece	1.40	2.28	0.90	4.01	78.9[c]	70.4	74.1[c]	67.3	39.6[f]	36.4	35.6[f]	34.0	22.3[d]	18.6	19.2[d]	16.9	Greece
Iceland	2.19	4.17	0.55	1.30	80.3[a]	75.0	75.7[a]	70.7	41.4[a]	38.0	37.7[a]	35.2	23.3[a]	20.4	20.0[a]	18.6	Iceland
Ireland	2.15	3.73	0.82	2.93	77.0[d]	71.8	71.0[d]	68.5	38.0[d]	35.4	33.0[d]	32.8	20.0[d]	18.3	16.0[d]	16.3	Ireland
Italy	1.30	2.41	0.83	4.39	80.0[b]	72.3[e]	73.5[b]	67.2[e]	41.4[b]	37.0[e]	35.7[b]	33.1[e]	22.9[b]	19.3[e]	18.3[b]	16.7[e]	Italy
Japan	1.53	2.00	0.46[a]	3.07	82.1	70.2	76.1	65.5	43.2	34.9	37.7	31.0	24.6	17.8	20.1	14.8	Japan
Luxembourg	1.64	2.28	0.92	3.15	77.9[c]	71.9	70.6[c]	66.1	39.4[c]	35.8	33.2[c]	31.7	22.4[a]	18.3	17.8[a]	15.9	Luxembourg
Netherlands	1.61	3.12	0.65	1.79	80.3	75.5	74.0	71.6	41.7[b]	37.8	35.9[b]	34.8	23.4[b]	19.9	18.3[b]	17.8	Netherlands
New Zealand	2.20	..	0.83[a]	2.26	78.3	73.9	72.4[a]	68.7	40.0[a]	37.0	35.5[a]	32.7	22.2[a]	19.5	18.2[a]	16.3	New Zealand
Norway	1.92	2.90	0.70[a]	1.89	79.8[a]	75.9	73.4[a]	71.4	41.2[b]	38.3	35.5[b]	35.1	22.9[b]	20.1	18.3[b]	18.0	Norway
Portugal	1.42	3.01	1.08	7.75	77.9[a]	67.2	70.9[a]	61.7	40.2[b]	36.2	34.3[b]	31.9	22.0[b]	18.6	18.0[b]	15.9	Portugal
Spain	1.28	2.86	0.78	4.37	80.3[a]	72.2	73.2	67.4	..	36.6	35.8[f]	33.1	23.2[b]	19.0	19.0[b]	16.5	Spain
Sweden	2.12	2.13	0.61	1.66	80.4[a]	74.9	74.8[a]	71.2	41.6[a]	37.2	36.7[a]	34.5	23.3[a]	19.3	19.1[a]	17.3	Sweden
Switzerland	1.60	2.44	0.62	2.11	80.9[a]	74.1	74.0[a]	68.7	42.3[a]	37.0	36.6[a]	32.8	23.9[a]	19.2	19.1[a]	16.2	Switzerland
Turkey	3.58	6.40	5.65	19.74	68.4[a]	49.7	64.1[a]	46.5	35.4[a]	32.0	31.5[a]	29.9	18.1[a]	15.9	15.8[a]	14.7	Turkey
United Kingdom	1.82	2.69	0.74	2.25	78.8	74.2	73.2	68.3	40.0	36.9	35.1	31.9	21.9	19.3	17.6	15.3	United Kingdom
United States	1.80		0.89	2.60	78.8[a]	73.1	72.0[a]	66.6	40.2[b]	36.5	34.8[b]	31.2	22.7[b]	19.5	18.6[b]	15.8	United States

Notes
.. not available
a 1990
b 1989
c 1987
d 1986
e 1961
f 1985
g 1988

Sources: *OECD Health Data*, OECD, Paris, 1993.
OECD Health Systems: Facts and Trends, 1960–91, OECD, Paris, 1993.

Source: OECD in Figures, 1994 Edition, pp. 46-47.

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Table A-7

Employment: Labor Force

EMPLOYMENT I

	Total Labour Force				Total Civilian Employment					
	Thousands 1992	Change since 1982 %	Female Participation Rate[1] %		Thousands 1992	Change since 1982 %	Agriculture Forestry and Fishing[2] %	Industry[2] %	Services[2] %	
			1992	1982						
Australia	8,666	24.4	62.1[a]	52.0	7,669	19.8	5.3	23.9	70.8	Australia
Austria	3,679	11.4	58.0	50.2	3,546	11.2	7.1	35.6	57.4	Austria
Belgium	4,237	2.8	54.1	48.3	3,724	5.3	2.6	27.7	69.7	Belgium
Canada	13,873	15.6	65.1	58.9	12,240	15.3	4.4	22.7	73.0	Canada
Denmark	2,912[a]	8.9[b]	78.9[a]	72.6	2,612[a]	10.3[b]	5.7[a]	27.7[a]	66.6[a]	Denmark
Finland	2,527	−0.6	70.7	72.4	2,163	−8.6	8.6	27.9	63.5	Finland
France	25,109	5.8	58.7	54.7	22,032	3.7	5.2	28.9	65.9	France
Germany	30,949	8.4	58.6	52.9	28,706	9.6	3.1	38.3	58.6	Germany
Greece	3,934[a]	6.9[b]	40.8[a]	36.4	3,634	2.9[b]	22.2[a]	27.5[a]	50.3[a]	Greece
Iceland	143[a]	..	80.5[a]	60.3	140[a]	..	10.7[a]	26.4[a]	62.9[a]	Iceland
Ireland	1,334[a]	4.9	39.9[a]	37.6	1,113[a]	−1.6[b]	13.8[a]	28.9[a]	57.3[a]	Ireland
Italy	24,612	8.0	45.8[a]	39.8	21,271	7.0	8.2	32.2	59.6	Italy
Japan	65,780	13.9	61.5[a]	55.9	64,360	14.2	6.4	34.6	59.0	Japan
Luxembourg	165[a]	3.1[b]	44.7[a]	41.3	162[a]	2.5[b]	3.3[c]	30.5[c]	66.2[c]	Luxembourg
Netherlands	7,133	..	55.5	39.0	6,576	..	4.0	24.6	71.4	Netherlands
New Zealand	1,636	..	63.2	45.5	1,467	14.4	10.8	22.6	66.6	New Zealand
Norway	2,130	6.8	70.9	64.3	1,970	3.1	5.6	23.5	71.0	Norway
Portugal	4,764	10.0	61.9	54.4	4,498	..	11.6	33.2	55.2	Portugal
Spain	15,432	12.8	42.0	32.5	12,359	11.4	10.1	32.4	57.5	Spain
Sweden	4,429	1.7	79.1	75.9	4,195	−0.6	3.3	26.5	70.2	Sweden
Switzerland	3,573	9.3	58.5	55.3	3,481	6.9	5.6	33.9	60.5	Switzerland
Turkey	20,696	16.9	34.2	..	18,600	16.2	43.9	22.1	34.0	Turkey
United Kingdom	28,149	5.5	65.0[a]	57.1	25,181	6.8	2.2	26.5	71.3	United Kingdom
United States	128,548	14.9	68.9	61.3	117,598	18.2	2.9	24.6	72.5	United States

Notes:
.. not available
[1] Defined as female labour force of all ages divided by female population aged 15–64
[2] See also pp. 26–27
[a] 1991
[b] 1991/81
[c] 1990

Source: *Labour Force Statistics: 1972–1992*, OECD, Paris, 1994

Source: OECD in Figures, 1994 Edition, pp. 8-9.

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Table A-8

Employment: Part-Time

EMPLOYMENT II

	Part-Time Employment as % of total employment						Female Part-Time Employment % of total part-time employment		Self-Employment % of total employment		
	Both Sexes		Women		Men						
	1992	1982	1992	1982	1992	1982	1992	1982	1992	1982	
Australia	24.4	17.1	43.3	36.2	10.5	6.0	75.1	77.9	15.7	15.7	Australia
Austria	9.1	8.0	20.5	18.9	1.6	1.5	89.1	87.8	10.2	16.0	Austria
Belgium	11.8[a]	6.4[b]	27.4[a]	16.3[b]	2.1[a]	1.3[b]	89.3[a]	86.2[b]	14.1[a]	13.7	Belgium
Canada	16.8	14.4	25.9	25.1	9.3	6.9	70.0	72.0	9.7	8.9	Canada
Denmark	23.1[a]	23.7[b]	37.8[a]	46.5[b]	10.5[a]	5.6[b]	75.5[a]	86.9[b]	9.1[a]	11.8[b]	Denmark
Finland	7.9	7.7	10.4	11.6	5.5	4.1	64.3	72.0	14.2	12.7	Finland
France	12.7	9.2	24.5	18.9	3.6	2.5	83.7	83.9	12.6	16.4	France
Germany	15.5[a]	12.0[b]	34.3[a]	28.9[b]	2.7[a]	1.6[b]	89.6[a]	91.9[b]	9.0	8.7	Germany
Greece	3.9[a]	3.3[b]	7.2[a]	6.6[b]	2.2[a]	1.8[b]	62.9[a]	62.4[b]	34.8[f]	38.9	Greece
Iceland	..	..	..	..	..	..	..	..	17.9[a]	12.5	Iceland
Ireland	8.4[a]	6.6[c]	17.8[a]	15.5[c]	3.6[a]	2.7[c]	71.6[a]	71.6[c]	21.7[a]	20.8	Ireland
Italy	5.4	5.1[b]	10.5	10.1[b]	2.7	2.9[b]	67.9	61.4[b]	24.4[a]	23.6	Italy
Japan	20.5	15.9	34.8	29.1	10.6	7.3	69.3	72.0	13.5	16.7	Japan
Luxembourg	7.5[a]	6.3[c]	17.9[a]	17.0[c]	1.9[a]	1.0[c]	83.3[a]	88.9[c]	10.6[a]	12.4	Luxembourg
Netherlands[1]	32.8	18.7[b]	62.9	44.6[b]	13.4	6.9[b]	75.0	74.6[b]	9.6[a]	12.4	Netherlands[1]
New Zealand	21.6	14.8	35.9	30.7	10.3	4.9	73.3	80.0	20.1	..	New Zealand
Norway[2]	26.9	26.6	47.1	53.3	9.8	7.5	80.1	83.6	9.0	10.3	Norway[2]
Portugal	7.2	7.3[d]	11.0	14.7[d]	4.2	2.6[d]	67.4	77.9[d]	24.5	30.4	Portugal
Spain	5.9	5.8[e]	13.7	13.9[e]	2.0	2.4[e]	76.8	71.5[e]	21.4	22.1	Spain
Sweden[3]	24.3	25.0	41.3	46.5	8.4	6.4	82.3	86.4	9.5	7.7	Sweden[3]
Switzerland	..	..	..	..	..	..	..	..	..	..	Switzerland
Turkey	..	..	..	..	..	..	..	..	31.9	..	Turkey
United Kingdom	23.2	17.9[b]	44.6	40.0[b]	6.1	3.1[b]	85.4	89.6[b]	12.2	9.2	United Kingdom
United States	17.5	18.2	25.4	28.1	10.8	10.6	66.4	67.2	8.5	8.9	United States

Notes
.. not available
1 Break in series in 1985
2 Break in series in 1987
3 Break in series in 1986
a 1991
b 1981
c 1983
d 1980
e 1987
f 1990

Sources: *Employment Outlook*, OECD, Paris, July 1993;
Economic Outlook, OECD, Paris, December 1993;
Labour Force Statistics: 1972–1992, OECD, Paris, 1994

Source: OECD in Figures, 1994 Edition, pp. 10-11.

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Table A-9

Labor Force Participation of Women with Young Children

Table 1.5
Labor Force Participation Rates of Women[a] with Children under Age 3 in Selected Countries[b]

Country	All Women	All Women With Children Under Age 3	Lone Mothers With Children Under Age 3[c]
United States	68.5	52.5	45.1
Canada	66.8	58.4	41.3
Denmark	79.2	83.9	80.9
Germany	55.8	39.7	50.4
France	60.1	60.1	69.6
Italy	43.3	45.0	68.0
Sweden	80.0	81.0	81.0
United Kingdom	64.3	36.9	23.4

Source: Constance Sorrentino, "The Changing Family in International Perspective," *Monthly Labor Review* (March 1990): 53. Published data from U.S., Canadian, and Swedish labor force surveys; unpublished data for other countries provided by the Statistical Office of the European Communities from the European Community labor force surveys.

[a] Women ages 60–64 are included in Canada and Sweden. Lower age limits are 16 for the United States and Sweden, 15 for Canada, and 14 for all other countries. For participation rates of women with children, no upper limit is applied for the United States or Canada. These differences do not distort the comparisons because very few women under 16 have children, while few women over 60 live with their children.

[b] Data for the United States are for March 1988; Canada and Sweden—annual averages for 1988; data for all other countries are for spring 1986.

Includes divorced, separated, never-married, and widowed women.

Source: Sheila B. Kamerman and Alfred J. Kahn, eds., Child Care, Parental Leave and the Under 3s: Policy Innovation in Europe (Westport, CT: Auburn House, 1991), p. 15.

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Table A-10

Public Sector: Government Revenue, Expenditure, Employment

PUBLIC SECTOR

	Current General Government Revenue % of GDP	Current General Government Expenditure % of GDP	Government Final Consumption Expenditure % of GDP							Net Government Saving % of GDP	Government Employment¹ % of total employment	
			Total	Defence	Public Order and Safety	Education	Health	Social Security and Welfare	Housing and Community Amenities			
Australia	33.7[a]	36.6[a]	18.6[a]	2.2[a]	1.3[a]	4.1[a]	3.2[a]	1.0[a]	0.3[a]	−2.9[a]	17.5	Australia
Austria	47.2[a]	45.7[a]	17.8[b]	1.0[b]	0.8[b]	4.0[b]	4.6[b]	3.2[b]	0.0[b]	1.5[a]	21.0	Austria
Belgium	50.2	55.2	16.8[c]	2.6[c]	1.6[c]	6.2[c]	0.5[c]	1.0[c]	0.2[c]	−5.0	19.0[a]	Belgium
Canada	43.1[a]	47.9[a]								−4.9[a]	20.3[a]	Canada
Denmark	55.5[a]	57.2[a]	25.2[b]	2.0[b]	1.0[b]	5.4[b]	4.8[b]	5.9[b]	0.2[b]	−1.7[a]	30.4[a]	Denmark
Finland	53.3	56.2	24.9	2.0	1.4	6.2	5.5	4.0	0.7	−2.9	24.5	Finland
France	46.1	48.5	18.0[d]	2.9[d]	0.8[d]	4.6[d]	3.0[d]	1.4[d]	1.1[d]	−2.4	23.3	France
Germany	45.3	44.4	18.3[b]	2.2[b]	1.5[b]	3.5[b]	5.6[b]	2.2[b]	0.3[b]	0.9	14.7	Germany
Greece	39.9	47.1	20.0[e]	5.9[e]		2.8[e]	2.2[e]	0.3[e]		−7.2		Greece
Iceland	36.3	33.4	20.7	0.0	1.3	4.1	6.9	1.6	0.7	2.9	18.4[b]	Iceland
Ireland	40.3[b]	41.9[b]								−1.6[b]	14.2[a]	Ireland
Italy	43.3	51.3	17.5[a]	1.9[a]	1.7[a]	4.8[a]	3.6[a]	0.8[a]	0.5[a]	−7.9	15.7	Italy
Japan	34.4[a]	25.4[a]	9.2[a]	0.9[a]		3.1[a]	0.4[a]	0.6[a]	0.6[a]	9.0[a]	5.9[a]	Japan
Luxembourg	52.9[c]	45.0[c]								7.9[c]	10.8[a]	Luxembourg
Netherlands	54.1	55.3	15.3[d]	2.7[d]	..	4.6[d]	..	0.7[d,f]	..	−1.1	12.9	Netherlands
New Zealand	..	..	..	..	..	..	..	..	..	..	22.1[a]	New Zealand
Norway	55.3[a]	52.9[a]	21.5[a]	3.2[a]	0.9[a]	5.5[a]	4.9[a]	2.3[a]	−0.1[a]	2.4[a]	28.7[a]	Norway
Portugal	37.6[b]	39.3[b]	15.4[c]	2.6[c]	1.5[c]	3.9[c]	3.3[c]	0.7[c]	0.2[c]	−1.8[b]	13.6[b]	Portugal
Spain	38.6[a]	38.8[a]	15.2[e]	1.7[e]	1.1[e]	2.8[e]	3.7[e]	1.6[e]	0.9[e]	−0.2[a]	14.7[a]	Spain
Sweden	60.0[a]	59.8[a]	27.0[b]	2.6[b]	1.4[b]	5.2[b]	6.5[b]	5.2[b]	0.5[b]	0.2[a]	32.2[a]	Sweden
Switzerland	34.7	35.0	..	..	..	..	..	..	..	−0.4	11.7	Switzerland
Turkey	..	..	..	..	..	..	..	..	..	..	..	Turkey
United Kingdom	38.8[a]	39.7[a]	21.3[a]	4.3[a]	2.0[a]	3.9[a]	5.1[a]	1.7[a]	0.6[a]	−0.9[a]	19.9[a]	United Kingdom
United States	32.2[a]	36.4[a]	18.1[a]	..	..	..	..	..	..	−4.2[a]	14.9[a]	United States

Notes
.. not available
1 Producers of government services, except for Australia, Austria, Canada, France, Ireland, New Zealand, Spain and Switzerland, which are general government
a 1991
b 1990
c 1986
d 1989
e 1988
f Social Security included

Source: *National Accounts*, OECD, Paris, 1994.

Source: OECD in Figures, 1994 Edition, pp. 40-41.

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Table A-11

Taxation

TAXATION[1]

	Total Tax Receipts % of GDP	Tax Structures as % of total tax receipts						Rate Schedules of Central Government Personal Income Tax[2]		Disposable Income of Average Production Worker as % of gross pay[3]		
		Personal Income Tax	Corporate Income Tax	Social Security Contributions		Taxes on Goods and Services	Other Taxes	Lowest Rate %	Highest Rate %	Single Person	Married with two Children[4]	
				Employees	Employers							
Australia	29.2	41.4	14.5	0.0	0.0	27.7	16.3	20.0	47.0	77.2	85.6	Australia
Austria	42.1	21.9	3.5	13.9	16.2	30.7	14.0	10.0	50.0	75.2	92.3	Austria
Belgium	44.9	30.3	6.0	11.1	21.8	25.6	5.2	25.0	55.0	64.7	89.3	Belgium
Canada	37.3	40.7	5.5	4.8	10.2	27.3	11.4	17.0	29.0	74.8	85.7	Canada
Denmark	48.3	53.4	3.3	2.4	0.7	33.3	6.9	22.0	40.0	53.3	67.5	Denmark
Finland	37.7	48.5	3.7	0.0	7.5	37.4	2.9	7.0	39.0	68.3	83.0	Finland
France	44.2	13.5	4.5	13.0	27.1	27.1	14.8	5.0	56.8	74.8	88.8	France
Germany	39.2	27.1	4.3	17.1	20.1	26.7	4.7	17.0	55.0	63.4	77.6	Germany
Greece	38.3	12.5	4.5	14.2	13.8	45.5	9.5	18.0	50.0			Greece
Iceland	32.4	26.4	2.6	0.3	6.7	51.4	12.6	32.8	32.8	81.9	116.9	Iceland
Ireland	37.5	32.3	5.9	5.2	9.2	40.7	6.6	29.0	52.0	67.6	79.2	Ireland
Italy	39.7	26.4	9.6	6.6	23.2	28.1	6.2	10.0	50.0	72.9	83.4	Italy
Japan	30.9	26.9	20.0	11.4	15.6	13.5	12.7	10.0	50.0	84.5	90.6	Japan
Luxembourg	48.5	22.2	15.5	11.4	14.2	25.4	11.3	10.0	50.0	75.9	98.4	Luxembourg
Netherlands	47.0	26.2	7.3	22.8	7.1	25.4	11.2	13.0	60.0	59.6	66.8	Netherlands
New Zealand	36.0	45.0	7.0	0.0	0.0	35.4	12.5	24.0	33.0	76.6	78.6	New Zealand
Norway	47.1	25.7	9.7	8.4	16.3	34.9	5.0	7.0	14.0	67.8	84.8	Norway
Portugal	35.6	17.8	8.4	10.1	16.3	41.9	5.4	15.0	40.0	82.9	92.7	Portugal
Spain	34.7	23.4	7.7	5.7	25.4	28.2	9.7	25.0	56.0	82.7	87.8	Spain
Sweden	53.2	34.2	3.1	0.0	26.9	26.9	9.0	20.0	20.0	72.0	83.0	Sweden
Switzerland	31.0	34.3	6.3	10.8	10.6	18.0	20.1	1.0	13.0	80.1	90.4	Switzerland
Turkey	29.4	28.7	6.1	7.6	11.0	29.3	17.4	25.0	50.0	66.5	66.5	Turkey
United Kingdom	36.0	28.5	8.9	6.7	10.4	32.7	12.9	25.0	40.0	73.8	83.5	United Kingdom
United States	29.8	34.9	7.3	11.8	16.5	16.8	12.7	15.0	31.0	74.0	81.0	United States
EC Average[5]	41.2	26.1	7.2	10.5	15.8	31.7	8.7	17.8	50.4	70.1	83.2	EC Average[5]
OECD Average[5]	38.7	30.1	7.3	8.1	13.6	30.4	10.5	16.8	42.2	72.6	84.9	OECD Average[5]

42

43

Notes

.. not available

1 1991

2 International comparisons have to take into account differences between countries in: the point at which income first becomes taxable; the amount of tax reliefs; rates of employees' social-security contributions; rates of local income taxes. In some countries lower tiers of government levy significant taxes; in 1991 the countries with flat rates were Belgium at 7%, Canada 17%, Denmark 30%, Finland 16%, Iceland 7%, Norway 27%, Sweden 31%. The tax rates vary by region; the figures given are typical or are averages. The countries with progressive rates were Japan at 5–15%, Switzerland 5–30% (cantonal and communal in Zurich), the United States 6–11% in New York City (state and city tax)

3 This percentage is influenced both by the tax level and the relative weight of taxation from personal income taxes and employees' social-security contributions

4 Takes account of family allowances and/or tax reliefs

5 Unweighted

Sources: *Revenue Statistics of OECD Member Countries, 1965–1992*, OECD Paris, 1993.
The Tax/Benefit Position of Production Workers, 1989–1992, OECD Paris, 1993.
Fiscal Affairs Division, AF

Source: OECD in Figures, 1994 Edition, pp. 42-43.

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Table A-12

Relative Poverty Rates, Selected Countries

TABLE 76.—LEVELS AND TRENDS IN RELATIVE POVERTY RATES,[1] AT 40 PERCENT ADJUSTED MEDIAN DISPOSABLE INCOME AMONG CHILDREN IN EIGHT WESTERN NATIONS DURING THE 1980s[2]

Period I

	United States[3] (1979)	Australia (1981)	Canada (1981)	West Germany[4] (1981)	Sweden[5] (1981)	United Kingdom (1979)	Netherlands (1983)	France (1979)	Average[6]
All children[6]	14.7	8.6	10.2	1.3	2.1	3.3	4.0	4.7	7.4
One-parent families[7]	46.1	33.6	39.9	3.3	3.7	10.9	1.5	11.9	25.3
Two-parent families[8]	7.2	6.5	7.2	0.6	1.8	3.0	0.7	3.4	4.7
Extended families[9]	13.7	3.6	5.3	3.5	NA	0.5	18.6	8.0	6.5

Period II

	United States (1986)	Australia (1985)	Canada (1987)	West Germany (1984)	Sweden (1987)	United Kingdom (1986)	Netherlands (1987)	France (1984)	Average
All children	20.4	9.0	9.3	2.8	0.8	7.4	3.8	4.6	7.4
One-parent families	54.2	34.6	37.1	15.9	2.0	8.5	3.8	13.1	21.2
Two-parent families	11.5	6.9	7.0	2.2	0.9	NA	NA	NA	5.7
Extended families	22.4	4.4	4.9	2.7	NA	NA	NA	NA	8.6

Source: U.S. House of Representatives, The Committee on Ways and Means, The Green Book (Washington, DC: U.S. Government Printing Office, 1993), p. 1454.

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Table A-13

Family Allowances, Selected Industrial Countries, 1991-1992[a]

(Monthly Amounts in Dollars)[b]

Country	Child's Ordinal Position				Age & Other Supplements
	1st ch.	2nd ch.	3rd ch.	4th ch.	
Belgium (1992) (employer)	$ 71.40	$140.10	$208.99	$208.99	6-2, $25.96 12-16, $40.24 over 16, $42.84 over 16, $49.33 (others)
Denmark (1992)	flat rate - per child under 6, $102.55 7-17, $ 77.89				
Germany (1992)	$ 44.14	$ 83.08[c]	$140.20	$154.00	
Finland (1992)	$ 81.62	$ 92.10	$114.18	$143.84	
France (1991)	d	$114.62	$146.72	$146.72	Age 10-15, $35.05 over 15, $61.66
Ireland (1992)	$ 27.26	$ 27.26	$ 27.26	$ 38.94	
Luxembourg[e] (1991)	$ 61.46	$126.02	$225.03	$184.64	Age 6-12, $15.00 over 12, $45.25
Netherlands[e] (1992)	$ 54.52	$ 64.90	$ 67.50	$ 67.50	
Norway (1992)	$136.95	$143.55	$162.53	$170.90	
Portugal (1992)	$ 16.30	$ 16.30	$ 24.45	$ 24.45	
United Kingdom (1992)	$ 77.89	$ 61.01	$ 61.01	$ 61.01	

Sources: European Observatory on (of) National Family Policies, National Family Policies in EC Countries, 1991 and Trends and Developments in 1992 (W. Dumon and T. Nrielant) (Brussels: Commission of the European Communities, DGV, 1992 and 1994); Erika Neubauer, et al, Twelve Routes to Family Policy in the European Community (in German) (Bonn: Ministry for Families and Seniors, 1993), Vol. 1, pp. 274-6; Jonathan Bradshaw, et al, Support for Children: A Comparison of Arrangements in Fifteen Countries, Department of Social Security, Research Report No. 21 (London: Her Majesty's Stationery Office, 1993), Appendix.

Notes:

[a] We include all EU countries plus Norway and Finland. Spain abolished its child allowance in March, 1991. The Greek scheme is too complex to summarize in this type of table. Italy has a means-tested system with variations by occupational sectors.

[b] We relied mostly for standardization on EU analyses translated into European Currency Units which we converted into dollars. In several instances we made direct conversion from country currency. There are variations among sources depending on the month of reporting or the month for conversion rates, therefore all numbers should be regarded as ± 1-10 %. Nor do these numbers signify the relative purchasing power of these currencies in their countries. For such considerations see our Table A-1 for 1991 and 1992 exchange rates and purchasing power parities.

[c] Germany, in fact, has a two-tier family allowance system. Those above a relatively high threshold receive lower per child benefits for second and subsequent children.

[d] A "first" child in a French family receives no allowance. We then show results for families with two, three, and four children.

[e] In Luxembourg and the Netherlands, a child's allowance is affected by age, ordinal position, and number of children in a family. We present here a simplified schema.

Source: Sheila B. Kamerman and Alfred J. Kahn, Starting Right: Investing in the Youngest Americans (New York: Oxford University Press, 1995, forthcoming).

Table A-14

Basic and Job Protected Maternity/Parental and Extended Parental Leaves

OECD Countries, 1991-1992

Country	Maternity/ Paternity as Indicated			Extended Parental Leave		Maximum Total Maternity and Parental
	Duration in Weeks	Benefit as % of Wage	Other	Duration	Benefit	
Australia	---	---				
Austria	16	100		3 years	Varies	3 years
Belgium	14	79.5-75				
Canada	15[a]	60		10 weeks	60%	25 weeks[a]
Denmark	28	100	Paternity 2 wks	52 weeks	80% of UIB	1.5 years
Finland	18	80	Paternity 2 wks	28 weeks 2+ years	80% Flat Rate	3 years
France	16[b]	84		2 years	Paid for by those w. 3+ child.	3 years
Germany	14	100		2 years	Flat Rate	2 years + 1 yr unpaid
Greece	14	50+ dep. benefit				
Iceland	6 mos	Flat Rate+ dep. ben.	All Parental			
Ireland	14	70				
Italy	5 mos	80		6 months	30%	
Japan	14	60		1 year	---	
Luxembourg	16	100				
Netherlands	16	100		6 mos/PT		
New Zealand	6 mos	Flat Rate	Inc. Tested			
Norway	18[c]	100-80	18 incl. 12 Parental	27 weeks	100/80	42 weeks

Table A-14 Continued

Basic and Extended and Job-Protected

Maternity/ Parental and Extended Parental Leaves

OECD Countries, 1991-1992

Country	Maternity/ Paternity as Indicated			Extended Parental Leave		Maximum Total Maternity and Parental
	Duration in Weeks	Benefit as % of Wage	Other	Duration	Benefit	
Portugal	3 mos	100				
Spain	16	75				
Sweden	12 mos	80/90	All Parental	6 months Right to PT work	Flat Rate	1.5 years Guaranteed until a child is 8
Switzerland	10	Varies				
Turkey	12	66 2/3				
United Kingdom	14[d]	90[d]				
United States	---	---				

[a] Plus two unpaid weeks.

[b] 6 months for third or subsequent children.

[c] In 1993, the Norwegian policy was extended to 52 weeks with replacement of 80% of salary, or 42 weeks with 100% replacement (each to an income maximum).

[d] As of late 1994, the United Kingdom leave became available to the full work force, covering 14 weeks, while those who previously had more generous benefits were protected. See United Kingdom case.

Source: Sheila B. Kamerman and Alfred J. Kahn, Starting Right: Investing in the Youngest Americans (New York: Oxford University Press, 1995, forthcoming).

Table A-15

Child Care Coverage Rates for Children Aged 0-3 and 3-5 in Selected Countries, 1990/1992

	Percent of Children in Child Care, Full and Part Day	
	Ages 0-3	Ages 3-5
Country		
Belgium	20	95+
Britain	2	43[a]
Denmark	58[b]	75
Finland	48[c]	72
France	29	97+
Germany	5	80[d]
Italy	6	91
Japan	21	52
Sweden	29[e]	79
United States	26	71[d,f]

Notes:

[a] Since compulsory school begins in the U.K. at 5, this figure is for the 3-4 year olds only.

[b] This figure is for children from the age of 6 months, when the basic maternity leave ends, through age 2.

[c] This figure is for 1 and 2 year olds, after the conclusion of the 10 1/2 month parental leave.

[d] These are largely part-day programs.

[e] This figure is for the 0-3 group. Since the parental leave is fully paid for 1 year and partly paid for another 3 months, only toddlers (1-2 year olds) are in care. Thus the "real" coverage rate for 1-2 year olds is probably similar to Finland's.

[f] Almost all 5 year olds are in either kindergarten or first grade; 44 percent of 3-4 year olds are in pre-primary programs.

Source: Sheila B. Kamerman and Alfred J. Kahn, Starting Right: Investing in the Youngest Americans (New York: Oxford University Press, 1995, forthcoming).
Table compiled from country and international sources.